MANAGEMENT AND POPULATION

—A Systems View and Review
of
Family Planning Programme in India

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To

Shashi R. Ram

The divine Polynesian dancer

ABBREVIATIONS

AIIMS	All India Institute of Medical Sciences.
ANM	Auxiliary Nurse Midwife.
ARC	Administrative Reforms Commission.
CFPI	Central Family Planning Institute.
CGHS	Central Government Health Services.
ECAFE	Economic Commission for Asia and the Far East.
IUCD	Intra-Uterine Contraceptive Device.
KAP	Knowledge, Aptitude and Practice.
LHV	Lady Health Visitors.
MCH	Maternal and Child Health
NIFP	National Institute of Family Planning.
NIHAE	National Institute of Health Administration and Education.
NPA	Non-Practicing Allowance.
PHC	Primary Health Centre.
UN	United Nations
UNDP	United Nations Development Programme.
UNFPA	United Nations Fund for Population Activities.
WHO	World Health Organization.

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PREFACE

India is second to no other country in recognizing the problem of growing population and designing a programme with a structural means to deal with it. To begin with, the programme of family planning was well conceived and laid out. The primary health centre as attached to the health organization was the logical unit to place reliance on for executing the family planning programme. In course of time other units of the administration joined the basic primary health centre units but, to this day, the primary health centre units are the ones which are supposed to reach the majority of people living in villages. Therefore, even though experiments are being conducted in various spheres like commercial marketing of condoms, mass campaigns for sterilization, etc., an increase in the basic health units with other levels of supporting structures to provide the services of family planning is continuing. Thus the machinery for family planning has expanded, with a growth in the number of its personnel, amount allotted for expenditure and the number and variety of administrative units. From a descriptive analytical angle, an examination of this programme development during the past 15 years or so leads us to certain discussions and that is what this work attempts. In the discussions, the organizational layout is examined and methods of operation are subjected to scrutiny from a broad standpoint of programme policy, its success and results, the objective being to offer an insight into India's management of family planning and create interest for the exploration of real measures for the programme's success.

In doing so, an attempt has been made to bring a systems view and review of the organization and management of family planning in India. It is intended to encourage the reader to assess the general totality of conditions in which the pro-

gramme of family planning is operating. Accordingly it is a critical account of the organizational operations as perceived to be working in the family planning system of India. The purpose is to provide a groundwork for debate and discussion on issues of strategy, objectives and options being followed by us

It has been possible for me to write part of this book when I was a Visiting Professor at the East-West Population Institute, East-West Centre, Honolulu, Hawaii, for a year. I am grateful to Dr Paul Demeny, Director of the Institute, for providing me the time and opportunity to do this during my stay. I am also grateful to Dr. Lucien A. Gregg, Associate Director, Rockefeller Foundation, and Consultant at the East-West Population Institute, for discussing with me some of my ideas.

Upon my return to India, Prof. N. S. Ramaswamy, Director, Indian Institute of Management, Bangalore (IIMB), has shared some of his concepts with me. I am thankful to him for this as well as for his continuous encouragement to pursue my interest in management aspects of health and population control programmes. Two of my colleagues at the IIMB, Drs. S. Subramaniam and M. N V. Nair, have been responsible for keeping up my interest to see through this work in print. I wish to thank them for their intellectual as well as other support. My thanks are also due to Miss S Shyamala of the IIMB for designing the cover jacket. At the final stages of this work, secretarial assistance was given to me by Miss Blanche Manuel. I am thankful for her interest and effort, given at the most needed stage. However, I hasten to add that I alone am responsible for any acts of omission or commission.

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May, 1974.

ONE

Management And Population

Mankind is now making attempts to prevent the tragedy of too many people. The debate on the cause and effect of too many inhabitants on this earth is centuries old but the effort to control the cause and mitigate the effect is only a decade old. From a concern to its translation into a policy and programme and from a programme into action with a time-bound target are steps in the field of organization and management. This work concerns itself with the area of organization and management and raises issues and questions in the light of a managerial perspective. This perspective takes into question the policy, programme, strategy, options and actions being taken in the field of management of population policies or programmes, widely known as family planning. If management is for desired results and if the expected results are not forthcoming, the efforts and the very basis of these efforts must be examined and re-examined.

A programme of population management did not result either from Malthusian pessimism or from Marxian arguments. Many countries, in their efforts to raise the levels of living standards of their people, found the increase in numbers from year to year a major obstacle. The increasing costs of providing social services such as education and health to the growing numbers each year became another cause for thinking of a

population control programme. Added to this, stress is even felt in areas of basic governmental services like law and order. Success of health measures has aggravated the problem and accelerated the process towards launching a population policy and programme A beginning has been made by many countries. This by itself does not mean the job of controlling the population growth is on its way to completion or even on the road to a satisfactory accomplishment of the desired results within a stipulated time. From policy to programme, and from programme to objectives to be achieved with the strategy to be adopted through options that are available are in the real realm of management where thinking is fuzzy and actions are exploratory. Even the realization that management has a greater role to play in a population policy's action is relatively new and appreciation is slowly though unwillingly forthcoming. The attempt in this work is to highlight the management aspects of the family planning programme. To this extent, the "numbers game" which has been a predominant occupation of many scholars is viewed in the background.

In recent years, many scholars have drawn a picture of gloom and doom, describing the situation as hopeless. Biologist Dr. Paul R. Ehrlich "understood it emotionally one stinking hot night in Delhi".[1] William and Paul Paddock realized it as part of an impending famine.[2] Others of the same vein also despaired. But none attempted a programme solution in terms of organization and management. Solutions suggested varied from governmental action, policy and programme to voluntary attempts and action.

Present opinion on the status of management of family planning ranges from one of despondency to hope. Hope is expressed by Donald Bogue, on the premise that there has been a burgeoning field of family planning research and experimentation along with the incorporation of family planning as part of the official programme of national health and welfare

1. Paul R. Ehrlich (Ed.), *The Population Bomb*., Ballantine Books, New York, 1970, p. 15.

2. Paddock, W. and Paul Paddock, *Hungry Nations*, Little Brown and Co., Boston, Massachusetts, USA. Also, see *Famine 1975*, same publisher, 1967.

in many nations around the world. On the other hand, Philip Hauser[3] suggests that it is too premature to come to any optimistic conclusions. According to him, there are yet no satisfactory methods of measuring small changes in fertility over short periods and that the world is yet to witness a family planning programme which initiated a decline in fertility in a "traditional society" characterized by mass illiteracy and poverty. It is true that we are facing an uphill task. The thinking in this field is enriched by demographers, biologists, medical doctors, economists, educationists, sociologists, anthropologists, psychologists, nutrition experts, general administrators and a host of others. But without an integration of these experts' thinking, the programme manager has no useful policy guidance.

India is second to none in being aware of the population problem and in launching a massive programme with no parallel in its scale and manner. In terms of commitment of money and men also it is second to none. But the problem is that neither money and men nor organization and structure can launch a successful programme. Programme management has many variables, aspects and nuances. Since many experiments are conducted in India on a variety of scales in a vast field, they provide us with a background for an analysis. The examples of managerial problems and success areas can be seen here with a hindsight and foresight. Therefore management situations in this work are drawn from India. Management is multidisciplinary and the view it takes is conceptual as well as pragmatic. The stress here is on the latter with due consideration for the former in so far as it has a bearing on the programme of family planning.

Management Theory

The term "management" has acquired a variety of interpretations in different contexts as the discipline was developing,

3. Peterson, W. (Ed.), *Readings in Population Control*, The Macmillan Co., New York, 1972 The views of D. Bogue and P. Hauser are also taken (as quoted) from O. Harkavey, *Impact of Family Planning Programs on the Birth Rate*, a Ford Foundation paper reprint, Ford Foundation, New York.

and is developing even today. It is not the intention here to go through the variety of approaches, semantics, etc., which have come to management development, teaching and research.[4] However, for the purpose of dealing with the programme of family planning management, an elementary emphasis on the precepts of management is essential.

The terms "administration" and "management" are often used interchangeably. Administration broadly means "getting things done" in a framework called organization. Management is handling of tools and techniques to achieve the desired results and manipulation of the structure and people involved in a programme. To get things done in any field of activity requires a policy, and a policy leads to a programme. A programme has certain objectives to be achieved within a certain time limit and, for this, strategies of action are visualized. There are options in exercising strategies and there is also a time limit—so that the schedule is reached and objectives are met.

Thus, management is a system of authority and responsibility that is charged with a programme. There are several ways of looking at an organization designed for management. The most convenient and frequently utilized is the formal structure. In such a structure, units and groupings which form the organization are designed to do certain jobs to achieve the ultimate objective. People are to fit in these units to perform certain tasks.

Another way of looking at organizing for management is through the people in the organization. The human-relation element plays an important role in getting a job done. The working conditions, what a job means to an individual and a sense of belonging are all important considerations contributing to the success of a programme management.

Looking at organizing for management through different perspectives has resulted in different schools of thought.[5]

4. For different management theories and approaches see H. J. Koontz "The Management Theory Jungle" in *Readings in Management*, J. G. Hutchinson, Holt, Rinehart and Winston, Inc., New York, 1971.

5. See Koontz and O'Donnell, *Principles of Management: An Analysis of Managerial Functions*, McGraw Hill Company, New York, 1968.

Different disciplines have enriched this field. However, the "operational" or the "management process school" describes the organized body of knowledge, taking into consideration the knowledge and technique from other disciplines. The fundamental beliefs which are underlined in the analysis of management by the "process school" are[6] :

1. Managing is an operational process best dissected intellectually by analyzing managerial functions.
2. Long experience with managing in a variety of enterprise situations can be grounds for distillation of basic truths or principles having a clarifying and predictive value in the understanding and improvement of managing.
3. These principles can become the focal points for useful research both to ascertain their validity and to improve their applicability.
4. Such principles can furnish elements, at least until disproved and certainly until sharpened, of a useful theory of management.
5. Managing is an art that, like medicine or engineering, should rely on a thorough grounding in principles.
6. Management principles, like those of logical and physical sciences, are nonetheless true even if a practitioner in a given situation choses to ignore them and the costs involved in so doing, or attempts to accomplish some other benefit that offsets the cost incurred.
7. While the total culture and the physical and biological universe variously affect the manager's environment, as they do every field of science and art, management theory need not encompass all knowledge in order for it to serve as a scientific foundation of management principles.

Management is also a system. It is a system of an organized complex. And as an organized complex it is, as every

6. *Ibid*, p. 36.

system is, part of or related to another system. If family planning is viewed as a system, we need to understand the concept involved in the systems' philosophy. Family planning organization forms only part of a total system. The bigger system in several countries is the governmental system. Thus, there is need for bringing the Systems Approach to the theory and practice of management and population.

Systems Theory

As a system, management has interrelated variables, constraints and parametres to measure the effectiveness of the system. Viewed accordingly, management is simply an assemblage of objects which have interactions or interdependence with certain attributes or qualities. In a system, if control is complete and effective, it is called the closed-loop system. An automobile with the built-in mechanism of a cutout for the electrical supply system is an example of such a system. Otherwise an open-loop system could be seen in operation.

A system can be viewed from its following essential characteristics:

1. Every system is part of a larger system and has many subsystems. For example, the Department of Family Planning is part of a governmental system but has many subsystems, i.e., manpower subsystem, communication subsystem, etc.,

2. Every system—physical, biological or social—has a specific purpose to which all its subsystems contribute.

3. A system's essential characteristic is that it is an organized complex and has many variables in operation. Some of the variables are favourable, and some unfavourable. A change in any one variable affects the others. In family planning, literacy is often found to be a favourable variable and the "unfinished business of public health" may be an unfavourable variable.

The following characteristics are helpful in describing and identifying how a system operates.

1. Flow—of information, materials, money, etc.

2. Structure referring to physical and geographical aspects, organizational design, etc.
3. Procedure—pre-planned activity which affects the flow and structure.
4. Control—this is prevention and correction of deviations in a systems behaviour from those standards which are specified at a given time.

Systems Thinking

There are five basic considerations that must be kept in mind while thinking about the meaning of a system. They are[7]:

1. The total system objectives and, more specially, the performance measure of the whole system;
2. The systems' environment: the fixed constraints;
3. The resources of the system;
4. The components of the system, their activities, goals and the measure of performance; or subsystems;
5. The management of the system.

We shall consider these one by one.

There are two objectives of any system: (i) stated and (ii) real. For example, the stated objective of a student is to learn but his real objective may be the grade. He seeks the high grade because he can get scholarships and other opportunities in future.

In the case of the family planning programme, the stated objective is a reduction in the annual birth-rate from 41 to 25 per 1,000 by 1978-79. The real objective might be broadly economic development and social welfare, with stabilization of population, full employment and other improvements. A systems analyst sees what a system actually performs rather than what the system is supposed to do.

7. C. West Churchman, *The Systems Approach*, Dell Publishing Company, Inc., New York, 1968, p. 29.

How do we measure the *performance* of a system? For example, in a "health system", steps have been taken to eliminate smallpox. The performance of this system is measured by a reduction in the percentage of children susceptible to this disease. However, the success of the system will result in a reduction in infant mortality, and consequently an increase in population. If we take the family planning system, its performance may be measured by the percentage of reduction in the annual birth-rate. But the consequences of a reduction in birth-rate are felt in the field of employment, dependence of people on the earning population, and on other social services, i.e., education, health, etc. Have the policy-makers of this system considered the future man-power needs? Do they know how many people are needed for our future industries and business enterprises? Actually how large a population does India want? These are some questions the systems objectives need to answer.

The next aspect of a system is its *environment*, that is, what lies "outside" it. A system can do relatively little about the nature of its environment. For example, our system of family planning operates under a fixed budet sanctioned by Parliament, and it remains fixed irrespective of demands by any changes in the activities of the system. Thus, we can say that the budgetary constraints are one of the constituents of the environment of a system.

Environment is outside a system's control. It determines partly a system's performance. Thus, family planning has to operate in a country like India with the following constraints (which cannot be quickly changed by the total family planning system):

1. One criterion for the allocation of central finances to the States is the total population of a State. This criterion conflicts with the family planning programme as it would not be in the interests of the States to reduce the number of people if they want more finances allotted by the Centre.
2. Similarly, the number of seats in Parliament is decided on the basis of population. This again offers no incen-

tive to a State to make family planning an effective programme. A similar situation would exist at State Assembly, district and even panchayat levels.

3. In a democratic nation the strength of a community is in its numbers. There is, therefore, fear that some communities may multiply and so increase their political strength as opposed to other communities who freely adopt family planning as a way of life.

4. Family planning is a centrally sponsored and financed programme. States have no stake in it and, therefore, are impervious to its success or failure even though they are directly responsible for its implementation.

These are the factors within the external environment dictating the performance of a system. This external environment can be manipulated, within limits, over a period of time but the internal environment can be manipulated more rapidly.

The requirement schedule is one of most important aspects of the environment of a system. In the case of an industrial firm it is its sales which can be influenced by means of advertising, pricing, etc. And in so far as the demand for the firm's product is determined by customers who are outside the firm, the demand lies in the environment of the system.

In the case of the family planning system, the "requirement schedule" consists of the demand for various contraceptives and sterilizations. To some extent, the demand for them can be increased by advertising, incentives and the like. But, to a great extent, acceptance of family planning services and the demand for them depend upon the couples who are in the reproductive age groups. Hence the demand is conditioned by the environmental factors.

We shall now consider the *resources* of a system. These are men; money and equipment. A system uses them to get its job done. These are inside a system which can change and use resources to its own advantage. A system is free to engage people in whatever assignment it wants and spend on various activities. To give a specific example from the family planning

system, it decides what the doctors, auxiliary nurse midwives (ANMs) or motivators and others should do. The spending of the funds in India (Rs 387 million) in 1969-70 was as follows[8]:

> Services 43.6%; compensation payments for sterilizations and intra-uterine contraceptive devices (IUCDs) 16.4%; administration 13.5%; construction of centres 8.7%; mass communication 6.8%; cost of contraceptives 4.9%; training 3.7%; and research 2.4%. Coming to the time limit, the programme, for example, had to achieve certain targets in 1970-71 extending up to 1979-80.

The systems approach requires the construction of "management information system" which helps to make better decisions. Through this system it is possible to know why certain objectives were not actualized and whether there has been any non-utilization of resources. The real lessons we learn from this are the lessons of lost opportunities. For example, when extension educators were not employed, the performance of the family planning system was said to be poor but after they came into the field there was a visible improvement in the performance of the system.

A systems specialist considers not only the existing resources but also the manner in which they can be increased. For example, he thinks of how the family planning system's resources should be used to create better resources in future, by means of research or training and education of personnel, etc.

Components or *Subsystems* is the fourth item to be considered in the systems philosopy. In management science, terms such as "components", or "parts", or "subsystems" are used interchangeably. Traditionally, organizations are often divided into departments, branches, divisions, offices, etc. But a careful examination shows that these are not the real components of the system—it is a set of activities forming a subsystem which contributes to the total system. It is for this reason that the

8. *India's Family Planning Programme—A Brief Analysis*, Ford Foundation, New Delhi, July, 1971.

systems specialist ignores traditional lines of department, division, etc., and turns to the basic "mission", or "subsystems". Thus, the family planning function of the Government takes place not only within the Department of Family Planning but also in other departments, i.e., Information and Broadcasting, which educates people through brochures, radio talks, etc. This can be called the communication subsystem.

A systems specialist is particular in talking about subsystems rather than departments because it is possible to analyze subsystems and estimate their contribution to the total system. The reason for dividing a system into components or subsystems is to provide the management scientist with the kind of information he needs in order to tell whether the system is operating properly and what should be done next. The ultimate aim of component thinking is to discover those subsystems whose measure of performance is truly related to the measure of performance of the overall system. One obvious reason for this is that if the measure of performance of subsystem increases (other things being equal) the measure of performance of the total system should also increase. If this is not so, the subsystem is obviously not contributing to the system's performance. For example, if the performance of the distribution subsystem (which is a component of the total family planning system) increases, the total performance of the family planning system should also increase. Otherwise, that component is not contributing to the total performance of the family planning system.

The last aspect of a system is its *management*. The management of a system deals with the creation of plans for the system, i.e., considers the overall objectives, the environment, the utilization of resources and the subsystems goals, allocates the resources and controls the system performance.

The "management" of a system generates plans and ensures that they are carried out. If they are not, it is to be determined why. This activity is called "control". It does not simply mean the examination of the course of action but also implies an evaluation of plans and if required a change of

plans. In the working of a system, "control" examines how the overall objectives are being attained through the subsystem,

The "management" must receive information that should indicate where the system is going wrong so that remedial steps could be taken. This part of a system's activity requires the installation of a management information system.

The overall "objective" of the family planning system is a reduction in the birth-rate from 41 to 25 per 1,000 in 1978-79. The "environment" of family planning comprises the present status of knowledge, attitude and practice of the people about the goods the system delivers. Annual expenditure allowed on doctors, extension educators, ANMs and others comes under "resources" of the system. The subsystems of this system are delivery subsystem, communication subsystem, training subsystem, etc. The managers of the system are the Government of India, State Governments and various other organizations—they formulate plans for the system and see that they are implemented. There is supposed to be an information system throughout the family planning system which informs of deviations, if any, in the plans, the mission objectives, providing for an immediate corrective when deviations are observed. This process is called the "information loop". A very critical aspect of this loop is the determination of how quickly information should be transmitted. Too quick or too slow a response does not contribute to the effectiveness of the system. What is required is an "information-feedback loop" that permits the "management" to react to the environmental patterns in an optimal fashion.

In Appendix I the chart of the Department of Family Planning is described as an organizational chart. In Appendix II, entitled "The Family Planning System", the organized complex or whole is explained in some detail. The interdependence of the main Department of Family Planning and other departments/subsystems is presented here. This chart only shows the complexity of the system and does not attempt to show all the interconnecting lines in the flow of information, money and materials throughout. The objective is to visualize family planning as a total system and to take the subsystems

enumerated in the total system of family planning into consideration.

Any system in management can be considered as a subsystem of a larger system. For example, this world, even though a system, is part of the larger system called universe and, seen in this perspective, the world becomes a subsystem. In the total system of family planning, we can identify several subsystems in areas like training, control, communication, information, delivery and distribution, etc. Identification of a system and its boundaries depend on how we see the organized complexities with their information flow and product specification.

Focus Of Systems Management

A system is an "organized or complex whole, an assemblage or combination of things or parts forming a complex or unitary whole".[9] "System" connotes plan, method, order and arrangement. Thus, management scientists have found it convenient to bring many disciplines into an order, because of the multitude of interdependent variables and aspects. Programme managers often focus their attention on particular functions in specialized areas and tend to lose sight of the overall objectives of the programme and their role in the large system. The focus of the systems management is on providing a better picture of the network of subsystems and concerns itself with developing a systematic theoretical framework for describing the general relationship of any system to the empirical world.

The systems concept is a useful way of thinking about the job of managing. It provides a framework for visualizing

9. Johnson, Kast and Rosenzweig in *Readings in Management Control*, R. J. Mockler (Ed), Appleton-Century Press, New York, 1970

Two well-known works which represent an attempt to integrate a large amount of material are: (1) Darwin, *The Origin of Species*, (2) Keynes, *General Theory of Employment, Interest and Money*. Darwin integrated in his *Theory of Evolution* all life into a "system of nature", and Keynes connected many complicated natural and human forces which make up the economy.

internal and external environmental factors as an integrated whole. It allows recognition of the proper place and function of subsystems.[10]

So much about systems philosophy, management theory and its relation to family planning. Since family planning is part of the governmental system, and the governmental system is managed through public administration the role of public administration will be discussed in the next chapter.

10. Designing Management Systems, Johnson *et al*, in *Management Systems*, P. P. Schoderbek (Ed.), John Wiley and Sons, 1968, p. 113.

TWO

Role Of Public Administration

As previously mentioned, in attempts to prevent the tragedy of too many people, India's efforts rank second to none. But the realization as to how population affects public administration is still nascent; it is often felt that too many pending applications are a result of requests and demands by growing numbers in population. Thus, increase in the volume of work due to increase in the clientele population is a common explanation in public administrative agencies for delays and omissions. It is true that there is ostensibly a pressure of numbers making an impact on the quality and quantity of the administration. This is specially marked in India where most of the adminstration is "public"—Government-controlled, oriented or owned. A proliferation of activities in the ever widening horizons of planning and development has involved the Government in the most vital sectors of economy touching upon every sector of population. At the same time, population increasingly feels governmental influence in all its approaches, from necessities to the so-called luxuries.

India's public administration has travelled a long way from the days of the British Raj through the Nehru era. In

1952, the realization that public bureaucracy and administration needed reform and revitalization brought an American expert in public administration, Dr. Paul Appleby, to India. He submitted two reports recommending improvements in public administration. This one-man effort was subsequently followed, in the late 1960's, by the Administrative Reforms Commission (ARC). All these attempts have resulted in one definite achievement—an increasing awareness on the part of the people and the Government that reform in administration is not only desirable but also necessary for any progress. As the number of people served by the vast machinery of administration increased, demands for a certain type of services as well as the range of activities (in which functions of the services were involved) also increased. These ranged from simple regulatory to developmental regulatory services, as in the case of law and order, to industrial licensing on the one hand, and complicated national direction of industrial development by direct investment and control on the other. Nevertheless, the characteristics of the Indian public administration remained essentially bureaucratic, feudal and sluggish.

With an enormous growth in India's population (see table below), pressure on the administrative machinery also proportionately increased, but the machinery underwent only marginal changes, and these also not always in the direction of reform.

India's Population

Year	(in millions)
1921	251.4
1931	279.0
1941	318.7
1951	361.1
1961	439.2
1971	548.0

However, the immediate problem, in relation to population, which attracted the attention of the Government was the food

situation. Attempts made by public administrative agencies to deal with this problem resulted in our present agricultural policy. Nevertheless public administration still retains the characteristics discussed below.

Lack Of Programme Identity In Administration

Since ideology is of primary concern to the voter, and performance of secondary, promises and patronage are the basis of India's public administration. Political promises based on ideology, like bank nationalization, limitation of land holdings, expanding nationalization and the latest measure of "ceiling" on urban property, are programmes to be executed by civil servants. The Indian Administrative Service (IAS) is the crux of India's corps of programme administration. These men are executives for the top posts in Central and State Government organizations. In the wake of their new additional duties and a variety of programmes they have to administer, they are often non-depth decision-makers, because a short time of "posting" to a certain position or programme does not allow them to develop any programme for a success. They are often in conflict with specialist professionals, in fields like medicine and engineering, and this is aggravated by the artificial distinction made between those in "Government" and those not in it. The specialists, like medical persons, function in a bureau or directorate with technical advisory positions. They have to forward their plans to the Secretariat, where major policy decisions are taken by these "generalists" of the administrative service. Their decisions prevail, since they are located in the Secretariat where plans and ideas forwarded by the Directorate of Medical and Health Services are reviewed and finally decided upon. Family planning and population control programmes are no exception to this systemic constraint of public administration. Policy is formulated by those who may not even see its implementation, and what it involves.

The most outmoded and archaic part of the public administration of India is the system of "noting". It works like this : Every small proposal is examined by a clerk and a

"noting" made on it. He then passes it on to scores of other officers with some remote connection with the subject matter. For any single decision a file has to move at least 14 steps and/or stages, through different officers, causing delay, distortion and often death of a decision by inaction. Added to this, the final officer who can dispose of "the case" is often limited in his understanding of the subject in view of his meagre knowledge or the background to his job. The rapid rotation with which he occupies various positions makes the situation worse. For example, a Deputy Secretary for Health may be in the Home Affairs for a year or two, and then may be transferred to the Ministry of Health and Family Planning. He is fully aware that his stay in the Department of Family Planning may be for two years or even less. Therefore, the commitment, the concern and most of all an understanding of the programme is something that cannot be expected of him or of a person in a similar situation. However, programmes will continue with noting and counter noting—and with an ample evidence to defend anyone who did not contribute towards the making of a decision, often to the detriment of those who made a move towards a decision.

In brief, the Indian public administration suffers from:

(1) Too many levels and positions to effect any rapid programme decision and execution;

(2) Too many boards and committees with vague or obscure duties and lack of responsibility on the part of any single individual or group of individuals for any programme;

(3) Control-orientation—a legacy left behind by the British but still preserved by the present restrictive financial control. It produces good noting and files and is aimed at preventing leakage. But, in the process, it does not help get things done—a primary objective of any administration;

(4) Generalist administration "rides the saddle" of all programmes making expertise or professionals practically not responsible to the programmes. With regard

to this aspect, complaints about generalists by professionals are seemingly justified; and

(5) Efforts to reform administration are frustrated in this set-up.

The reports of ARC invariably go to the Ministries affected. There they are studied by those affected. Since few Ministers have time to read through these reports, the Secretaries of the Ministries go through them. In effect, senior civil servants or the upper bureaucracy who are secure and total in their grip on the administration act upon the reform to be administered to themselves!

Bureaucracy administers programmes, policies and even general precepts for some programmes. A typical successful administrator in the Indian bureaucracy is one who has reached the top through seniority, service in a particular cadre and an unblemished record (for undertaking the least amount of executive action so that he may stay out of any trouble). Once he reaches the top, he is supreme to give shape to his ideas, much to the discontent of some juniors who may have their own innovative ideas. To accept any junior's programme would, for him, be to contend with a competitor. Any such reckoning comes only if it serves the general purpose of that sector of bureaucracy, and if it does not conflict with the top bureaucrat's own ambitions.

Population policy and the family planning programme of India have to work within this general set-up of public administration, since these are largely governmental in character, inspiration and content. A review of the programme by taking family planning as a total system would serve to illustrate further issues in the management of population programme policy.

THREE

Family Planning System

The Origin

The population problem received attention for the first time in 1916 through a book by P. K. Wattal, entitled *The Population in India.* The thought process developed from then on, at various committees, conferences and other meeting places where statements were made, resolutions passed and intentions expressed. This resulted in an intellectual and political support but not a programme. The All-India Women's Conferences in 1931 and 1933 supporting birth-control, Tagore's opinion on the subject as expressed to Mrs. Margaret Sanger, and the support for a proposal in the Senate of the University of Madras in 1931 to provide instruction in methods of contraception were all pious statements with no programme content. The resolution of the National Planning Committee of the Indian National Congress in 1938, supporting population control for economic development, and the resolution moved by Mr. P. N. Sapru in the Council of States in 1960, to establish birth-control clinics in India,[1] are all indicative of legislative intent and purpose on this question. Nevertheless an intent

1. For a detailed account of all these developments see *Management of Family Planning—Policy and Perspective*, Ram, N. V. R., Administrative Staff College of India, Hyderabad, 1972.

cannot translate itself into a programme. However it was once again expressed in 1940 by the Health Survey and Development Committee under the chairmanship of Sir Joseph Bhore. The committee recommended provision of birth-control services for promoting the health of mothers and children.

However, the Famine Inquiry Commission (also known as the Woodward Commission) expressed a different view. They were of the opinion that a deliberate State policy to encourage practice of birth-control among the masses was impracticable. Their opinion was that a decline in the birth-rate would tend to follow, rather than precede, economic development.

Even though the first official initiative and action is said to be that of the Government of Mysore, which established two birth-control clinics in the State's two major hospitals, the idea of family planning as a nationwide programme did not take shape in India till the advent of her Five Year Plans.

First Five Year Plan—1951-1956

The First Five Year Plan made the initial overture to the problem of population control in India. The approach had an economic basis, but the programme mainly relied on clinical medicine.

The Planning Commission recommended in 1951:

1. Provision, in Government hospitals and health centres, of advice on methods of family planning for married persons who require such advice . . . . ;
2. Field experiments on different methods of family planning for the purpose of determining their suitability, acceptability and effectiveness in different sections of the population;
3. Development of suitable procedures to educate the people on family planning methods;
4. Collection, from representative sections of the population, of information on reproductive patterns, and on attitudes and motivations affecting the size of the family;

5. Study of the inter-relationships between economic, social and population changes;

6. Collection and study of information about different methods of family planning (based on scientifically tested experience in India and abroad) and making such information available to professional workers; and

7. Research into the physiology and medical aspects of human fertility and its control.[2]

The commission observed that a rapidly growing population does not help raise the level of standard of living and the course of action visualized was the opening of clinics to provide family planning services. Of Rs. 6.5 million made available for this programme, only Rs. 1.45 million was spent.

Second Five Year Plan—1956-1961

The Second Five Year Plan also shared the same idea. A family planning board came into existence at the Centre, with a director of family planning. State family planning officers were also appointed in different States, and training centres established to provide orientation for different kinds of workers who were to be engaged in this work. This was the beginning of the development of an extensive bureaucratic machine. However, from the point of view of the programme it was again the clinics established which provided the necessary advice and guidance to their clientele.

Third Five Year Plan—1961-1966

At the time the Third Five Year Plan came into operation, the family planning programme had functioned for a decade without any noticeable results. The Plan took a serious view of the low rate of savings and the growth in the labour force, resulting in serious problems for the achieving of high productivity and income. Therefore the programme of family

2. First Five Year Plan, Government of India, New Delhi, 1952

planning adopted an "extension approaeh" compared to its earlier "clinical approach".

The primary health eentre (PHC), which had been established as part of community development blocks, eame in as a handy devicc. As with agricultural and other extension workers, family planning extension workers started funetioning as part of the family planning bureaucracy which now is nationwide.

Fourth Five Year Plan—1969-1974[3]

The Fourth Plan continued the same approaeh with a proliferation of medical and non-medical bureaucracy forming a big nucleus of the family planning programme, extending to all parts of the eountry. We can now observe that the programme, in eontent and operation at its eurrent scale, is only eight years old. Till 1965, and until the emphasis was changed from clinic to extension approach, family planning had not assumed the importanee it now has; consequently, the population problem as related to eeonomie development was not a matter of operational eonsideration.

However, even at present the basie considerations of this programme are medical, welfare, health—and everything but eeonomic. The pronouneements on the programme of family planning generally do not give an eeonomie interpretation and the appeal is usually on anything else than on an eeonomic basis, e.g., the mother's health, disease prevention, ete.

Family Planning Enterprise

It would not be an exaggeration to say that the family planning programme has become a big enterprise in India as is evident from the fact that the investment on it has been increasing gradually from Plan to Plan. The following table

3. For the years 1967-68 and 1968-69, there were annual plans.

gives the detailed expenditure of the family planning programme.[4]

	Expenditure (in million rupees)	Total No. of Acceptors
First Five Year Plan	1.45	
Second Five Year Plan	21.56	152,637
Third Five Year Plan	248.60	3,504,536
1966-67	134.26	2,261,699
1967-68	265.21	2,984,026
1968-69	305.15	3,104,444
1969-70*	370.00	3,388,741
1970-71* (up to Aug. 70)	470.00	2,169,695
Fourth Five Year Plan (1969-70 to 1973-74)	3,150	(Proposed)

Note: Total expenditure prior to 1971 was Rs. 1,816.25 million with 17,565,778 acceptors.
*Provisional information as obtainable at the time of writing is provided.

Nearly 100,000 people including physicians,[5] administrators, para-medical personnel and others are working in this enterprise. In addition to the Central Government, there are 18 State Governments, 10 Union Territories and a large number of voluntary organizations involved in this programme. There are five central training institutes, 46 regional family planning training centres, 16 central family planning field units, catering to the needs of training for this programme, with 318 district family planning bureaus, 1,775 urban centres, 4,812 primary health centres and 28,912 sub-centres providing the services. In addition, there are 59 post-partum hospitals and 1,923 and 7,427 other institutions (hospitals, dispensaries, etc.) undertaking family planning work in the urban and rural areas

4. See, *Family Planning Programme in India*, Department of Family Planning, Government of India, New Delhi, 1971.

5. Data refers to the year 1970, as collected from the officials of the Ministry of Health and Family Planning.

respectively. Also, there are 419 mobile sterilization units and 463 mobile IUCD units attached to the district bureaus, rendering services in camps. In addition to the health organizations, there is a separate Nirodh marketing organization. There is one factory each in Kerala and Kanpur, manufacturing Nirodhs and loops respectively. The Government of India has an executive board as part of the Ministry of Health and Family Planning to expedite the execution of decisions.

The management of this enterprise is beset with many problems. Compared to the investment undertaken, the results achieved seem to indicate an unsatisfactory progress. Of the nearly 100 million eligible couples, only 12% to 15% have so far been covered by the programme. Provision of supplies and services is the central point of this enterprise. As the programme progressed, it was soon realized that the problem was not only of supplies and services but also of creating an effective demand for the goods and services which are put on the market. Managing a business which needs creation of an effective demand is different from managing one which has only supply and delivery as its focal point.

System And Structural Design Centre

Ever since 1965 when family planning activity was realized to be of critical importance, the basic approach to the problem of population control has crystallized itself into the following structural patterns:

1. Creation of a Department of Family Planning within the Central Ministry of Health and Family Planning.
2. Establishment of bureaus of family planning within the departments of health in all the States.
3. Increase in family planning staff at the district and primary health centre level.
4. Numerous organized camps.

The approach did not radically change except for the creation of new agencies added to the general health services. One notable change has been in the creation of a Department of Family Planning with the Commissioner as head of the technical

wing and a whole new set of technical officers under him, predominantly with a medical background. Whereas it is recognized that the urgency of a situation demands an innovative approach, the approach conceived by the governmental administrative set-up seems to be creation of a new department of family planning. Even though the delivery of services at the peripheries is done by the health department, planning and control of health operations at the Centre is done separately, since the department of health stands apart—with a Director-General of Health Services who serves as the technical head and is responsible for health planning.

The declared policy of the Government is to integrate maternal and child health services with family planning and to provide family planning as part of general health services. In practice, at the central level, family planning is recognized as a distinct service with a prestigious, separate departmental status. By contrast, in the same Ministry, the Directorate-General of Health Services stands at a bureau-level status. Structurally this is deliberately established to give family planning a preferred status. Hence the systems design does not contribute to the declared philosophy of integration of family planning with health services. This factor constitutes a major contradiction in the management of health and family planning services in India.

A deviation from the usual delivery system is the Nirodh (condom) marketing organization established in September, 1968. Nearly 100,000 retail outlets supply this product along with six of India's largest and most experienced consumer goods organizations serving as the primary distributors of Nirodh in a given region of the country. In 1971, an experiment in demand creation for Nirodh was conducted in Andhra Pradesh. With all the experience from the years 1965 to 1970, the system of family planning tells us that planning and control are particularly designed to be the function of the Centre and remain so.

In analyzing the system we have to take the historical legacy into consideration. This will help us ascertain the objectives of the designed programme and the implications underlying its

planning and control operations. The family planning system followed the below mentioned stages in its planning and operations.

1. At the initial stages the knowledge, attitude and practice surveys (KAP surveys) provided the basic information for the progress of the programme. Since a majority of the people were said to be aware of family planning services it was thought that supply of goods and services should get managerial attention. Therefore, plans were drawn up to build family planning clinics and provide contraceptive goods and services in conjunction with information dissemination.
2. After a few years it was realized that a market governed by desires, buyer preference, etc., needed to be manipulated by creating an effective demand. The management of demand creation and of supply outlet are the dual sides of the family planning enterprise for which the strategic planning and control executed at the central family planning level are totally inadequate. The manner in which the planning and control operations have proceeded has created a growth in the total family planning enterprise with additions in regard to complexity in management problems.
3. As the number of units in the organization and the diversification of methods increased, the attempt also to attract a greater number of consumers has not made much headway from the existing method and type of operation, except for creating a larger size and greater number of operating units.
4. The Central Ministry is the planner and financial controller. Its functions involve selection of alternatives in policies, objectives, procedures and programmes. But none of these have been attempted in any meaningful way by the Central organization.
5. The planning and decision-making process affects the entire programme and. because of the change and uncertainty, the planning function of the Centre must be a continuous process.

To cite a few examples of the fields in which planning alternatives, procedures and programmes are indicated:

1. Targets are uniformly fixed on population basis, irrespective of the birth-rate of the States.
2. The Centre pays 100% of the finance, but the facilities become the property of State Governments. Creation of such new property to be handed over to the States with no future proportionate investment return is a matter which speaks of non-systemic planning and control.
3. At the Centre, the Joint Secretary[6] is the only full-time person with meagre professional assistance to manage the organization. In late 1969, a reorganization was made by adding a planning, programming and evaluation unit at the Centre. This unit adds to the control capability of the department, but control requires managerial tasks and this is not being taken care of.

Since we cannot control unless there is a plan and since there is no plan at present, it is pertinent at this juncture to ask where India's family planning programme is, where it is going, what its objective should be and whether there is need for a revised plan at the Centre to meet the revised objectives. The table in Appendix III gives the position of the States in regard to the attaining of the birth-rate of 32 per 1,000 as an interim goal. The rate at which the programme is progressing and operating does not give us a reason to hope that this interim target can be reached. It is contended that, unless the system of management operations in family planning is changed, there is little chance of attaining, even in the distant future, the desired goal—a stabilized population.

Issues for consideration from the point of view of the system at the Central level are:

1. If family planning is to be organized as part of the total delivery system of health services, the organization, planning and control should not be so bifurcated

6. Since 1973 this position has been elevated to the status of an Additional Secretary.

at the Centre as they are at present. It appears from the linkages in the chart in Appendix II that the stress and importance given to the Family Planning Department at the Centre are such that health becomes a subsidiary part both in terms of expenditure and organizational lay-out.

2. As part of the health delivery system the categorical public health programmes have established the position of regional directors. Even though family planning is not a categorical programme, the position of regional directors has been established. The role of these regional directors in family planning has been one of co-ordination (by persuasion), reporting and rendering of any assistance they can. Controlling and planning functions for the region are not one of their functions as they could be. If there is an integrated health department at the Centre, the role of a regional director would be more specifically in the functional area of providing health, family planning, maternal and child health (MCH) services.

3. In a vast country like India the success of the programme depends upon decentralized operations with powers and functions given to regional officers. In this context, one can note that the regional offices are inadequately equipped for this task.

The focal points of the operations in the family planning organization network are:

1. Central Department of Family Planning.
2. Bureaus of family planning in States.
3. The district family planning bureau.

Health is a subject matter of State Governments, and family planning as part of health also becomes the operational responsibility of State Governments. But in view of the fact that the Central Government gives 100% financial assistance to the family planning programme, it has become the financial controller, planner and, to some extent, organizer of this programme.

The Centre also controls certain functions like medical research for improving contraceptive methods and has control over the supply and transport of goods to delivery points. In the field of mass communication, the role of the Centre is predominant in the sense that it exercises control over the choice of media and actually operates a direct mailing facility. The Centre also influences the activities of State Governments by means of staffing patterns and determining the conformity of objectives to the Centrally determined standards—by a control over reimbursement. Such controls often follow the "conformancy fallacy" of clinging to targets and written procedures rather than to achievement of the desired goals.

Central influence and control also apply to:

1. The training function.
2. The management information function (which is centrally designed with procedures).
3. Demographic institutions, social and medical research functions.

The direct role of the Central Government in the operations of the family planning programme is limited to the following:

(a) Its programme for 10 million employees of Central Government organization and field programmes in Union Territories; and

(b) The Nirodh marketing programme which is executed through commercial channels.

Other than this, the State Governments play a key role in the actual execution of the programme. Most of the field personnel are State Government employees and the physical facilities constructed from Central grants become the property of the State Governments. As a result, in order to execute the programme, the Centre is totally dependent on the States. State-level bureaus are the next hierarchies in the family planning organization which control operations. A bureau consists of a State family planning officer and supporting staff. Its functions are:

1. Supervision of the district family planning programme.
2. Administration of training programmes at district level for field workers.
3. Administering the mass-communication and transportation functions within the State.
4. Co-ordination of the flow of money, materials and information.
5. Financial and operational control over field activities, and the providing of leadership and direction to the programme in the State.

The role of a State family planning bureau is crucial in establishing a system of family planning services in the State. The actual operations are carried on at district level by the district bureau which has supervisory control over a wide range of facilities. These district bureaus have a difficult task of supervising a large number of units, programmes and activities. The total programme depends on how effectively these bureaus can perform the difficult task of accomplishing the goals set by the programme. The typical staff of a district bureau which is part of the State Directorate of Health and Family Planning consists of the following :

1. District Medical and Health Officer (Family Planning Officer).
2. Administrative Officer.
3. Lady Assistant Surgeon (IUCD).
4. Mass Education and Information Officer.
5. District Extension Educator.
6. Statistical Assistant.
7. Artist-cum-Photographer.
8. Projectionist.
9. Operation Theatre Nurse.
10. Auxiliary Nurse Midwife (IUCD).

However, since family planning is part of the health organization, the way in which different States incorporate it in their health organizations gives us the following patterns:

Type I
1. One Director for Health and Family Planning Services.
2. Unified Single Cadre.
3. One District Chief for Medical and Health Services.

Type II
1. One Director for Health and Family Planning Services.
2. Unified Single Cadre.
3. Two District Chiefs—one for Health and one for Medical.

Type III
1. Two Directors—one for Health and one for Medical Services—family planning under both depending upon institutional control.
2. More than one Cadre.
3. Two District Chiefs—one for Health and one for Medical.

Type IV
1. Two Directors—one for Medical and Health and one for Medical Education (family planning coming predominantly under medical and health services).
2. Single cadre envisaged.
3. Two District Chiefs—one for Health and one for Medical.

An analysis of typology in the hierarchy further extended to the district level gives a varied pattern of district health organizations in India. The following types can easily be seen:

Type I Two District Chiefs

(i) District Health Officer.

(ii) District Medical Officer/Civil Surgeon—looking after the district hospital only.

In this set-up the district health officer, responsible for public health work also, looks

after the family planning programme in the district.

Type II **Two District Chiefs**

(i) District Health Officer—responsible for health facilities.

(ii) Civil Surgeon—responsible for all medical facilities in the district.

In this set-up also the district health officer is in charge of the family planning programme in the district. However, in one State the family planning programme is directed by the district magistrate.

Type III **One District Chief with two Deputies**

(i) District Medical Officer of Health.

(ii) Deputy Chief Medical Officer
(iii) Deputy Chief Medical Officer
} each in charge of all health activities for a particular geographical area.

(iv) Medical Superintendent in charge of the district hospital only.

In this set-up the District Medical Officer of Health administers the family planning programme.

Type IV **One District Chief with three Deputies**

(i) Chief Medical Officer.

(ii) District Medical Officer (Health).

(iii) Deputy Chief Medical Officer (Medical).

(iv) District Family Planning Officer—working under the Chief Medical Officer.

(v) Senior Medical Officer for the district hospital —looking after the hospital in the district headquarters but working under the Chief Medical Officer.

Type V One District Chief with two Officers

(i) Chief Medical Officer of Health.

(ii) District Medical Officer in charge of the district hospital.

(iii) District Health Officer—looking after public health and family planning services.

Only recently, family planning, as part of the health organization, took a prominent position in the health sector. The way in which various States have translated the Central policy into an organizational structure shows what compromises have been made by the States on the competing demands of Centrally sponsored schemes like malaria, smallpox, family planning, etc.[7] Thus all programmes become an appendage to the medical and health organization; family planning is no exception.

7. For a discussion of different patterns of organization along with organization charts see Ram, N. V. R., *Management of Family Planning—Policy and Perspective*, Ch. II. 1971.

FOUR

An Appendage Of Health

Population control and family planning as its instrument is now, to a large extent, the task of health organizations. But the primary objective and focus of health organizations is not population control but, rather, the care of those who are ill. Even though the promotion of better health accelerated the problems of population, the interest of health organizations in controlling population did not develop at the same speed at which the population problem accelerated itself to the forefront.

When family planning developed as a nationwide programme, the community development programme was already in existence as an organizational model, and primary health organization (PHC) became a handy device for the policy-makers who looked for a convenient organization to entrust the responsibilities to. But the health profession, as a whole, was not ready for this responsibility; some doubt whether it will ever be. Those who doubt it base their premise on the contention that the nature and objectives of the health profession are not in harmony with the programme goal and content of family planning. This is a moot question. And those on the other side plead for a proper training to a medical doctor to

prepare him as a managerial physician to shoulder the responsibilities of programme administration. In this context it is essential at this point to go into a physician's background to ascertain his managerial abilities.

Background Of A Physician

It can reasonably be assumed that a medical graduate is a good clinician when he graduates from a medical school, though, of late, the quality of medical education has been the subject of some criticism To illustrate further, prior to 1960 there were two kinds of doctors in India: licentiates and graduates. The former received a licentiate diploma (LMP, LSMF., etc.) to practise medicine after three or four years in a medical school after their high school education. The latter received their MBBS degree after five and a half years' training in a university medical college. Further, the licentiates, though less qualified, played a useful role in providing medical help to the community—whereas the degree-holder assumed a superior position in the hierarchical set-up of clinical medicine. Leaders of the medical profession who advise the governmental policy-makers sought to do away with these two types of doctors on the ground that international standards require only one type of doctor. Consequently Indian considerations of international standards caused the elimination of licentiate courses in 1960.

Since then, only MBBS degree-holders are produced by Indian medical colleges. But the shortage of 23 per cent of teachers in the ever increasing numbers of medical colleges has affected the standard of teaching which is said to be going down. Therefore there is a clamour, though weak, by the medical profession against the opening of more medical colleges. Nevertheless political demands and dictates have forced an increase in them—from 12 (or so) in 1947 to 100 at present. These 100 medical colleges are to produce 12,500 medical graduates a year from 1975.

However, the question relating to family planning is one of ability of this doctor to manage the programme of family planning. It requires an expenditure of Rs 80,000 on the part

of the State to make him a licensed doctor but he is trained to be a clinician and not a manager. If he were to be posted to a primary health centre, he would view, for the first time, the cumbersome web of public administration procedures. His primary interest is the practice of clinical medicine. Aspects of community medicine or public health come next to his clinical interest, in so far as he has learnt it that way in his medical school. In other words, he is trained to be in a hospital, preferably under ideal conditions, to work with a most sophisticated equipment, to examine "cases", and "patients" rather than "persons". He is equipped to treat "diseases in man" rather than "man in disease". He would have a chance to learn about "people" and "human beings" only if he enters private practice, entirely on his own investment and risk. This learning will be outside the medical school and under the compelling necessity for survival in a competitive world. A young, Government-employed primary health centre doctor may not have to go through this training. His salary is protected and his service based on rules of seniority, etc., which are framed under the regulations of public administration. His possible transfer to a city or town hospital from the initial posting to a village primary health centre (where living accommodation, entertainment and other amenities are lacking) is dependent on various things including his connections and/or the influence he might be able to wield. Positions in towns and cities are few, and since there are fewer hospitals than the primary health centres, all doctors do not succeed in their attempts for a transfer from a health centre to a city or town hospital.

It is clear from this that family planning does not become a doctor's primary business, either professionally or organizationally. Organizationally it is woven into his command in the primary health centre, but he has neither the training, nor the background, nor the experience for it. A primary health centre is a complex organization composed of nearly 75 people. A doctor's knowledge of organization and management is restricted to hospital conditions; village conditions are alien to him. From the moment he enters his primary health

centre, his efforts would be either to have himself transferred or to further specialize so that he may have the opportunity of either working in a hospital or emigrating.

The above should amply explain why there are unemployed doctors and why many of them go to Sri Lanka or Singapore to take an ECFMG examination which enables them to emigrate to the United States. It is even questioned whether India needs MBBS type of training to serve the needs of its rural population. Professor Galbraith has said: "As a layman I have sometimes wondered if medical education has been really adapted to the situation of the poor countries. If we insist on high standards for the few, may we not deny medical assistance to the many?"[1] The UN Economic Commission for Asia and the Far East (ECAFE), in its Economic Survey Report of 1965, also mentioned that shortages of physicians are likely to continue in the developing countries as they are being over-trained relative to the objectives which they are to fulfil in their own situations and countries.

In spite of these facts and the fact that unlicensed medical persons and men in other systems of medicine like Ayurveda, etc. (80,000 of them as compared to 100,000 qualified ones)[2] largely fulfil the curative medical needs of a large majority of Indians in the villages, a realistic move to "modernize" the medical education is not forthcoming. The implication of this to family planning is enormous in so far as family planning is a part of integrated medical and health services In brief, we have a doctor not suited to India and who is also not a managerial physician carrying full responsibility for managing health and family planning at the grass-root level.

This brings us closer to two issues. First, as we have examined the background, preparation and role of the basic doctor in relation to family planning, we have also to examine the background, experience and role of his chief, the programme

1. See J. K. Galbraith, *Economic Development*, Harvard University Press, p. 85.

2. The unlicensed physicians call themselves PMPs (Private Medical Practitioners) and have now formed an association to persuade the Government to recognize them as registered medical practitioners

administrator of health and family planning services in a State. He is designated as Director of Medical and Health Services. With the advent of family planning as an important programme, his designation is often enriched with the addition of the word "family planning" to his title. Thus, he is often known as the Director of Health and Family Planning Services in the Directorate of Health and Medical Services, which he directs and heads.

The second issue is of the philosophy of integration itself as it relates to integration of health and family planning. First, we shall examine the general positional background of the Director of Medical and Health Services in a State, since he is the programme administrator.

Background Of A Programme Administrator

The background of most of health administrators in the Indian States lies in the long years of experience in the practice of medicine, more specifically in the practice of a speciality like surgery or gynaecology and obstetrics. To many, an appointment as director of health services and family planning is the pinnacle of success. From this position, they are expected to retire to complete their career. Retirement age in nearly all the Indian States is 55 years compared to 58 years at the Central Government. Many of the directors aspire to be selected for a position at the Centre either during their tenure as director, or at the end of their tenure as director. This extended service at the higher levels of administration would enable them to keep their job even after retirement. For example, one may get a job contract to head one of the many Government medical institutes or special projects. Some even aspire for a position at the World Health Organization (WHO) where the retirement age is 65.

The appointment to the post of Director of Health Services is a political decision but it is also often influenced by medical excellence and contacts in the executive branch of the Government It is rarely the privilege of a person working in the public health department to provide clinical medical services to important persons in the executive branch of the Government.

This is so beeause he works in a non-hospital based situation. Therefore, a person working in a hospital for most of his eareer specializing in treatment proeedures and techniques has a better chanee of beeoming the Direetor of Health Serviees than the one who is working in the field eontrolling publie health diseases. This sort of separation in terms of plaeement and operations has brought a eleavage between the publie health side of the profession and the eurative side. Over the years this has become an in-built feature in the health serviees strueture of India.

Since the Direetor of Health and Family Planning Services in almost all the States is a person whose baekground is elinieal praetiee, he laeks the knowledge and experienee of health administration at the field level. Sometimes a limited experienee in the field-level operation tends to develop in the director an attitude of indifference to that side of the programme. This may result in less importanee being given to a mass campaign programme like malaria. As a mass eampaign, the malaria eradieation programme has some experienee to share with the family planning programme. They are both field-level programmes and are both carried out on a large seale. The malaria programme is failing in its attempts to "eradieate" and now contents itself with "control" or "containment".[3] Whether the family planning programme will go the same way depends on the extent to which, organizationally and struetu-rally, it is a prototype of the malaria programme. Whereas this is a matter coneerned more with the integration of health services, i.e., integration of publie health and medieal sides of the department with family planning, the point to note here is that the elinieal profession is the leader of programme adminis-tration and that the profession has not yet fully prepared itself for this task.

The medieal profession, particularly the elinieians, have made speeial claims for the leadership of the family planning programme. They have argued that it is their responsibility

3. For an elueidation of the problems in this grea, see *Health Administration and Policy Development*, Ram, N. V. R , Booklinks Corporation, Narayanguda, Hyderabad (AP), India, 1971.

since the population increase has been the result of the improvement in health measures. If one were to grant full credence to their claim, they must also then bear the responsibility for discovering an effective, easily mass-administrable measure for population control. On this subject matter efforts are being made by them.

Public health workers, especially the medical men who are looking after the mass campaigns for the eradication of malaria, filariasis, trachoma, etc., join the controversy to forward their claim of being better administrators than their colleagues in the clinical profession. Their claims are based on the following:

1. Public health is a distinct speciality and takes community health into consideration.

2. By virtue of field operations, a knowlege of administration is gained by a public health doctor.

3. An individual-oriented clinical person cannot see the wider problems of administration and its implications.

4. Felt needs of the community are better answered by a public health doctor and on a mass scale, since he would be operating from his personal knowledge of community behaviour, aspirations, etc.

5. Achievements in the health field such as malaria control, etc., have been possible through the public health doctor, which the hospital side does not provide. The greatest good for the greatest number has been possible by the public health department.

6. The curative doctor has his own narrow speciality which should not be disturbed. He should not be placed on a job about which he knows little and has to learn by trial and error.

Those clinicians who contened the above express the following views:

1. Hospital administration is no less an experience than field experience.

2 Specialities provide curative services to those who were not cared for by the public health programmes.

3. By working long hours as a curative doctor and healing many individuals, a community feeling is acquired.

4. Surgery, as an art and science, gives an abundance of experience in team-work, and this is what is required of an administrator

The points in favour of each side can be expanded. These points with related issues were argued by each side at the time of administrative integration of the health services. This leads us to the next issue of the philosophy of integration of health services.

Integration Of Health Services

For a long time, until 1970, Indian States had two departments with two directors—the Public Health Department and the Medical Department.

The Public Health Department had the responsibility for public health programmes like malaria, smallpox, etc.; the Medical Department managed hospitals and dispensaries. But to promote comprehensive integrated health services from the grass-root level, starting with basic health services, integration of the two departments was visualized by many committees and experts.

"Basic health service" is defined as "a network of co-ordinated peripheral, intermediate and central health units, staffed by competent professional and auxiliary personnel and capable of performing effectively a selected group of functions essential to the health of the people living in an area".[4] This is a good definition but does not mean much if seen in terms of an organization and management or a viable unit for delivery of services. In the same manner, integration of health services has also been conceived. At least in the case of India the concept can be seen more concretely in so far as the thinking goes. The integration concept strives for integrated service

4. Suleman, Dr., *Basic Health Services* (mimeographed), WHO, Geneva, April, 1968.

conditions and privileges for the medical profession who are in graded service. Through this manner it is conceived that an improved service to the people, co-ordinated care, unified approach, etc., can be achieved.

The Health Survey and Development Committee in India (also called the Bhore Committee of 1946) recommended integration of curative and preventive public health services for the Centre and the States under one director of health services. The Health Survey and Planning Committee of 1961 (called the Mudaliar Committee) also recommended integration through a regional organization in each State between the headquarters and the district. The next step came by a resolution of the Central Council of Health at its twelfth meeting held in Srinagar in 1964. The resolution says:

> "The Central Council of Health taking note of the importance and urgency of integration of health services, and *elimination of private practice*[5] by Government doctors, recommends that a committee consisting of Dr. N. Jungalwalla, Director, National Institute of Health Administration and Education, and the Directors of Health Services of UP, Gujarat, Punjab, West Bengal, and the Director of Public Health, Madras, and a representative of the Indian Medical Association should examine the various problems including those of services conditions, *elimination of private practice*,[6] etc., and submit a report to the Central Government, in the light of these considerations, before 31st March 1965."

The report was, however, submitted in April, 1967. The Committee defined integration of health services as[7]:

(i) a service with a unified approach for all problems, instead of a segmented approach for different problems; and

(ii) medical care of the sick and conventional public health programmes functioning under a single administrator and oper-

5, 6 Italics by the author.

7. *Report of the Committee on Integration of Health Services*, Directorate-General of Health Services, C.H.S./Rev. 2, 1967.

ating in a unified manner at all levels of hierarchy, with due priority for each programme obtaining at a point of time.

The report described the steps taken towards integration by the different States of India and pointed out that the reason for non-integration was mainly administrative and psychological. The main steps recommended towards integration were:

(i) unification of cadre; and

(ii) terms and conditions of service providing:

(a) uniform scales of pay;

(b) drawal of pay according to the grade to which one may belong irrespective of the appointment;

(c) interchange and rotation of officers between clinical, public health teaching and research branches;

(d) a common seniority;

(e) chances of promotion on an overall consideration of years of service, merit, administrative capability, etc.;

(f) a special allowance for specialists and for special programmes and administration;

(g) orientation training, post-graduate studies and staff courses for medical officers;

(h) adequate financial and other incentives to medical officers posted in rural areas, declared by the State as attended by any special hazard or risks.

The recommendations are clearly indicative of the exposition of an integration concept as it affects the service conditions, pay, etc., of the medical profession. The concern seems to be to get better working conditions, more privileges in terms of non-practising and other allowances than provision of services in an integrated manner. The place of family planning in his scheme of integration is conspicuous by its absence.

Another high-level committee,[8] consisting of Dr. T. R. Tewari, Director of the National Institute of Health Administration and Education (NIHAE) and his colleagues, submitted

8. *Report on Integration of Health Services* (mimeographed), NIHAE, New Delhi, 1972.

a report on this subject. The members of this committee extensively toured many parts of India interviewing people from State headquarters down to the PHC level. It is disappointing to see that this report does not offer any model required for an integrated health services administration nor does it discuss the place of family planning in the scheme for providing integrated health services to the people. It is, therefore, of little use to policy-makers by way of guidance for improving the delivery of services and demand creation for family planning services.

Integration requires an organizational cohesion as well as an attitude of mind on the part of the administrators. On this matter the thinking of the various committees is not explicit. As a result, the same issues affecting civil service conditions such as non-practising allowance (NPA), etc., are discussed with relatively no consideration for the optimal unit required and the organizational structure desired.

NPA—The Bane Of Contention

This is a historical legacy. At some time in the Indian administrative history of medical practice, a privilege was conceded to the medical doctor by granting him an allowance to compensate for opting for a salaried service instead of his own privately established clinic or service. Perhaps it was assumed that the doctor would have earned more money had he been in private practice than in Government service and therefore this compensation was provided to make Government service more attractive. The logic behind it is nowhere listed convincingly but the reasonings for granting this privilege have been built up for several years. The result has been the granting of more and more of this privilege in larger amounts as associated with the basic salary of a doctor.

As the number of Government-owned hospitals and dispensaries increased, the number of doctors also increased and the private practice using hospital equipment, diagnostic privileges, etc., also increased. Some of the State Governments in India allowed their salaried doctors to practise

privately on condition that this be done outside of the governmental duty and after hours. As a result, patients thought that to get better attention of a Government doctor, they had to approach him at his "home office" and pay his private fees. It is, therefore, natural that the doctor who received a private fee would be inclined to give better hospital facilities to that patient. Hospital bed allotments, etc., were thus subject to other considerations.

In this system of private practice, a patient has to make his own arrangement for payment of fees to his doctor, anesthetist, diagnostician and so on. Since there is no schedule of fees drawn up by any medical association, each takes what the patient can "afford" to pay; this would also depend on the nature of disease, urgency, etc. This is not a happy situation.

However, the system has been working as described for a number of years and NPA was instituted as a remedy to the situation. Those who opted for it were prohibited from doing private practice.

The privilege of private practice was found so advantageous that some of the doctors[9] who had established themselves in a particular place refused to accept an order of transfer. Some even resigned their Government job to set up their own private practice. However, the majority in the medical profession preferred NPA, to secure themselves an income compensatory to private practice. Consequently, the Central Government and also many State Governments decided to ban private practice by giving doctors an equivalent allowance ranging from 25 per cent of their basic salary to 33⅓ or 50 per cent. The rules were so framed that an specialist would receive a 50 per cent addition to his basic salary, irrespective of whether he applied his specialty or worked in a Government office for many years. Often, placed in a Government office for several years, a doctor would forget to update his knowledge of medicine. According to the opinion of some

9. The information on this aspect of NPA is gathered from discussions with medical doctors practising in various hospitals in several States.

clinical medical experts who are in continuous practice, these types of medical executives would find it hard to re-establish themselves as clinicians at that particular juncture of their career. Thus, for a Government medical executive, NPA is an advantageous proposition.

Many doctors prefer NPA and work in a Government hospital. This way, they can have the salary and NPA and, if they prefer, can also have a "private" practice. It is difficult to check it and the introduction of NPA has not resulted in any improvement in the services.

Family planning does not provide an ample opportunity for private practice, except for the incentive money provided for an operation. This is a small amount compared to what one may expect for an operation of hernia, appendicitis, etc., where the fees are at a higher level and are sometimes continuous.

For the non-medical personnel working in the field of medicine, NPA has proved a discriminatory measure. For example, if a Professor of Biochemistory with qualifications of PhD, DSc, etc., is appointed to that post he, after a number of years of service in the lower ranks, will receive his basic salary only, whereas if an MBBS or an MD is appointed to this post his salary will be approximately 75 per cent more as the addition of a 50 per cent NPA to his basic salary would also carry other allowances like house rent allowance, etc., which are calculated on a percentage basis on the basic salary. Thus a person with a medical qualification would be getting nearly 75 per cent more salary than the non-medical person equally qualified though in a different branch of knowledge. This seems hardly reasonable. The principle of "equal work for equal pay" is replaced in this instance by "more salary" for the "weighted" medical degree whether the job in question warrants it or not.

Medical bureaucracy has been claiming more and more positions in the administrative level on the ground of technical content. It is of common knowledge that, at higher levels

of administrative operations, technical content becomes less and less and ability to manage a programme becomes an important consideration. Nevertheless, with the creation of more general administrative positions at Government level, more and more positions and at least an equal number of so-called equivalent technical positions are also being created.

In this struggle for more positions in the health and family planning bureaucracy, public health and medical personnel compete among themselves for positions. As a natural corollary, positions in general administration also have to increase to cope with the technical positions for which the general administrators either support or supervise. A great part of the increase in the number of people working in the family planning system can be attributed to this.

Specialities and super-specialities in medicine are created to provide easy mobility. For example, in medical education, a Professor of Preventive and Social Medicine can become a Professor of Epidemiology or Public Health and from here can move on to the newly created positional specialities such as community medicine, social medicine, administrative medicine, etc. These terms give dubious technical content to the proliferating positions and departments. Since money needs to come from somewhere, and as family planning has become a new source, these are often created and justified as furthering the cause of family planning.

Medical Education And Family Planning

Family Planning is not a speciality in medical education like radiology, surgery, gynaecology, obstetrics, etc. But the claim of many disciplines has extended to family planning and newly invented disciplines are in a hurry not to be left behind.

The claim of surgeons, gynaecologists and obstetricians is simple and direct; it is their speciality and privilege to give technical services. Rarely these technical personnel have a flair for administration but some do become good administrators. Many clinicians accept that they are too preoccupied

with clinical work to go into another speciality, e.g., programme administration. But there are exceptions. Bombay's family planning chief and several others can be cited as examples.[10]

Among others in the medical profession, claims to family planning management are made by public health administrators, preventive and social medicine specialists, and the newly created "terminology specialities" like community health, community medicine, administrative medicine, etc. An examination of the curriculum of these specialities will indicate that these are extensions of public health to include some aspects of sociology, psychology, and rarely some theory on administration. However, one can note that psychology is having a dominating place in the content of "social sciences". The system of medical education has accepted this brand of "social sciences" in its curriculum without examining its relevance and utility. It is disappointing to note in the course contents that the management sciences have not been given due recognition. Yet this is what is required to give a knowledge of the essentials of programme administration.

Health Bureaucracy

All these are indicative of the growth of a health bureaucracy. To a great extent, this has been possible because of expenditure on account of an extended family planning programme. Money provided for the purpose of family planning is used to build physical assets and properties for the health department. In the name of family planning, investment in the health industry has increased. Expenditures for the programme of family planning have made possible the appointment of a huge army of personnel as an appendage to the department of health.

The untested but much debated philosophy of integration of medical and public health professions has taken a further

10. See, Ram, N. V. R., *Management of Family Planning—Policy and Perspective*, Administrative Staff College of India, Hyderabad, 1972.

stride in the name of family planning, only to the advantage of those who will be part of this bureaucratic enterprise.

The family planning programme, as an appendage of health, is not a visible important part in its operation, strategy, impact and achievements but has contributed to the creation of employment opportunities for many, and has also added to the number of positions in the sphere of what may be called the Law of Sinecure and Success.

FIVE

The Law Of Sinecure And Success

This law is generally applicable to public administration but its discovery has been possible through observations, particularly in certain developmental programme administration. Simply stated, the law is:

1. A sinecure is often created for persons who are moving up in the bureaucracy.

2. Sinecures aided by promotional efforts rather than genuine work and contribution to the programme administration tend to ensure success more readily to a position holder.

This law observes that an individual succeeds from position to position or moves from position to position, invariably to a higher level, holding offices which can rightly be called sinecures. These sinecures are so created by the incumbents that unless they operate as an office with considerable promotional work and no definite list of duties, the guarantee of success is remote.

How It Starts[1]

Whenever a new kind of programme operation is initiated one person will be designated as the head, at a particularly high level, to conduct the operation. Since many foreign dignitaries pass through New Delhi or Bombay and seek a rapid insight into this "first of its kind" programme, this chief person spends most of his time briefing them. His contacts in that particular field thus increase. Soon he finds it difficult to devote full time to his job and develop more insights into that programme—a result of his preoccupation with public relations and promotional work. Research and administratson are delegated to others on the operational level. The result is that the position promotes him, and to keep up his position he promotes himself as an authority in the field. In this struggle between promoting himself and handling his workload, promotional work takes up so much of his time that he can do little positional work—therefore his position, in terms of his major contribution to the programme, becomes a sinecure.

Some Examples

Take, for example, Dr. X, a most successful university professor. He wrote his one research work in the forties and since then all his writings have been done jointly with his students or as director of research projects wherein relevant members of the team wrote the project report under the professor's guidance. If one were to look for an original thought or recommendation in the work of past 30 years of Dr X, he would be sadly disappointed. Yet, Dr. X has established himself as a successful professional in his field, with promotion from professor to director and from there to an ambassadorship. This is promotion for professionalism applied successfully, following the Law of Sinecure and Success. The way the professor

1. This theory of Law of Sinecure and Success is based on conceptualization of ideas as things would operate in a bureaucratic set-up of programme administration. Instances cited as examples do not refer to any particular individual or group.

accomplished it was by following the golden principle of holding a sinecure with promotional efforts for success. Before he became a professor his promotion as a good professor was ensured by a "promoter" in the organization; with the help of the "promoter" he established his reputation—not based on his writings but on his ability to establish a sinecure of his own called the "Institute of Geotactics" of which he became the director. From there on, he crept into positions of prominence on committees, boards, international conferences and places of importance—all these successive steps from the base of his own institute of which he was the director, promoter, publicity builder, image projector, etc.

Professor ABC also wrote only one book—a descriptive essay. His position as a unique contributor on this subject, at a particular juncture, promoted him to a certain post. From then on, he promoted himself from one position to another. Afterwards, his contribution to his profession was meagre but success in his professional status was unlimited. Ultimately he retired from an international advisory position and established his own research organization in India.

The above are cases of academics. Bureaucrats are no exception. Mr. Z, after his retirement, was given a three-year contract to head a government department which was to introduce innovative ideas for the development of a specific developmental programme. He was to administer a number of training programmes to fulfil this objective and also conduct research of an operational nature for implementation and experimentation. At the end of his three-year term, he got an extension for two years, and retired at the age of 63. Even after his retirement, he is employed by a reputed professional agency as a director of a research project. Yet, he had never written a research paper. He held the post with laurels, by virtue of his promotional efforts. As the head of the department he had attended every international meeting and conference, frustrating the desires of the younger men and other professionals.

Take the example of Dr. Y. He has been the head of an academic department for at least 20 years and is thought

of as one of the most successful researchers in his field. He is on many government committees. Eight to ten months of his working time in a year is spent not in his home institution but in the national capital, New Delhi, where he successfully promotes himself to recognition and to continuous selection for these committees and other boards of administration. As a result of the influence created by his placement on these boards and committees, his place of prominence in his profession is assured with no commensurate contribution to the science on which the professor is supposed to be an authority. Y's students are proud to work with him even though they do not get any guidance due to his various preoccupations. He has no time to devote to his subject because of the sinecure which he has created for himself; his success lies in managing the sinecure to a level of authority and competence where his name would be commanded. He is the fund-raiser for his research projects, employment agent for his students, influencer of decisions according to his favourite ideas or policies in the complex machinery of the committee system of the government, and ultimately manager of his image as thinker, researcher and administrator.

One can create a sinecure for himself or wait until a sinecure searches him out. If one is a director of a large organization, he must meet a number of dignitaries, and explain his own contributions and those of his organization. Thus more time is spent on promotional and public relations efforts; and the elements of sinecure are thrust on him. Soon he finds that less time for professional work will carry him near more attractive promotional work for recognition and reputation. Promotional work, therefore, is considered by many as an easier method for gaining recognition than genuine professional work, leadership and competence.

Not all incumbents of a sinecure are professionally unsound. Some very brilliant scientists, administrators, researchers who are dedicated to hard work and professional contributions are compelled to adopt sinecure methods in order to succeed. Many who intend to balance their professional and promotional work equally eventually find themselves in

a difficult situation of having to sacrifice profession for progress to attain a sinecure.

Take for example Mr. Z. He went abroad and returned after a number of years of work there to get into the mainstream of India's professional life, to contribute his experience gained abroad. This meant giving up a lucrative job in a foreign country. His colleagues, who had already occupied sinecures, found him a threat and branded him as an "idea enthusiast" with Western chauvinism. Relentless, Mr. Z produced work related to Indian conditions and formulated programmes for execution. This posed a challenge to those in sinecures, and they considered him an overenthusiastic professional, ambitious and far ahead of his time. Therefore, he was asked to integrate his work with others, which meant sharing his work, ideas and reputation for the benefit of the sinecurists. The made of "integration" was to bring out his publication in the name of the institution with which he worked, thereby assuring equality of opportunity to others and maintainng the anonymity required in a government organization. Desiring individual recognition, he looked for job opportunities elsewhere. In the course of this struggle, he became a short-time consultant and the resulting opportunity for promotional work delivered him, in due course, at the doors of a sinecure.

A person in a sinecure is conscious of his reputation (professional and otherwise) and keeps it up with the help of his supporters, to promote his professional integrity and create a demand for his services. He goes from conference to conference, from meeting to meeting. His job is not to stay in his office and do the work, but to make others feel that a lot of work is being done by him. One way of doing this would be to attend all conferences and claim to be a "field level" and "grass-root level" worker.

Since most people desire recognition in their profession, and since such recognition depends, to some extent or, in certain circumstances, to a great extent, on promotional efforts rather than on work efforts, the successful man eventually finds himself in a sinecure. In other words, generation

of reputation and recognition becomes a primary concern lessening the importance of professional work. An organization with a sinecure leadership will have individuals contributing to sinecure positions. Individuals proceed towards their goals individually, and since the pattern for success is already established, work accomplishment is conditioned to the extent it contributes to the total success of the sinecure promoters. The organizational objective is not even secondary when compared to the sinecure holder's objective. Since sinecure executives have to satisfy other colleagues whose job is to support the promotion for sinecure, the satisfying and maintaining of an equilibrium of the contending forces concerned becomes a secondary objective of the organizational chief.

The result of the operation of the Law of Sinecure and Success is that, sooner or later, one finds oneself in a position where he must promote his own sinecure or else be content with being pushed into non-recognition and with no opprtunity for promotion. Sinecurism is a profession by itself. From the top echelon of administrative leadership of political executives in the country down to the "babu",[2] the practice of sinecurism is widespread but the objectives vary. The purpose of doing so differs. The "babu" having found his "level of advancement" at an end wants to be recognized as the "key man" in the organization when things do not move, or to show that he can move papers which cannot otherwise be moved. This way he gets recognition. With this, he advances himself. His superiors recognize him as "the man" to rely upon to get through the "muddle of papers". He writes suitable "notings" to get the troublesome "case" finally "disposed of", to the relief of his boss He is thus useful to the sinecure hierarchy and becomes part of it. As such he is protected as a "knowledgeable person" and his promotion to a place where he will again promote his reputation to be useful to the sinecure executives is assured. So, to reiterate, the law runs thus:

> Every person sooner or later has to find himself a sinecure to be successful. People who have occupied the greatest

2. Lowest-level civil servant in India—a clerk or even a messenger.

sinecure are likely to be the most successful men in their profession.

Sinecure is widespread in the Government and, therefore, in the field of family planning which is said to be a multidisciplinary effort. All kinds of professions are working in it and many disciplines are contributing their share to the formulation of research and training. The result has been many research projects, conferences, seminars, colloquiums, discussion forums and training programmes. All these need a subject-matter, organizational base, and single or multidisciplinary orientation. Thus psychologists look at it from the point of view of knowledge, attitude and practices; sociologists from the socio-cultural; social scientists from a "social" angle; extension educators from the extension education level; doctors as part of health and medical care, and so on. All these points of view are necessary and helpful in so far as these studies and conferences give ideas and generate forces for a better implementation of policy and administration

As it happens, many meetings and researches do not serve this purpose; they serve the purpose of a gathering of professionals in one or many disciplines who are espousing the cause of family planning. To this extent, it serves an ideal and a hope. Beyond this, the hope and ideal are transferred to those who are in the particular professions than to the family planning programme. Positions and promotional efforts start to operate for the Law of Sinecure and Success; and multiplicity of positions is the result of this law. Otherwise how can we explain the workload of 100,000 personnel in the family planning programme? If each were to motivate 100 persons a year, the number of vasectomies or acceptors per year would be 10 million.[3] But, the programme has so far done only little over this number of sterilizations.

The prevalence of this law is often facilitated by the creation of positions, basing it on the disciplines or the

3. One source states that there were less than 21 sterilizations and seven IUCD insertions per technical person employed in the programme in 1968-69. See Banerji, D., *Family Planning in India: A Critique and a Perspective*, People's Publishing House, New Delhi, pp. 35-47

descriptive subject-matter rather than duties. Since the time urgency of family planning was realized at Government level, creation of positions became the logical corollary. A reorganization at the Ministry of Helath and Family Planning brought about the establishment of the Department of Family Planning separate from the Directorate of Health Services. Further, this department got an elevated status by its being located in the Secretariat, where decisions are taken, as opposed to the advisory status of the Directorate of Health Services. In this department, to reiterate the special, urgent nature of the population problem, a technical wing was created. This wing, headed by the Commissioner of Family Planning, provided a position for a medical executive. Since the Secretariat does not normally wish to give up its hegemony for administrative decisions and executive leadership, the Department of Family Planning also got a secretarial wing with a Joint Secretary at its head.

The secretarial wing, or the Joint Secretary, deals with policy, planning, budget, grant, foreign assistance and administration.[4] Thus, the actual programme administration lies in the hands of the secretarial wing. The technical wing, or the Commissioner of Family Planning, is responsible for training, mass media, programme evaluation and research, supplies, transport and services. The division of work between the two wings is thin and artificial: any wing responsible for policy and administration also needs a feedback by way of management information for evaluation. Besides, in the federal set-up of India, since the Centre consists of all "staff" and no "line" (except in case of small programmes managed directly), training, evaluation and research need be done as close to the level of operation as possible. In addition, mass media is not really under the control of the Ministry of Health and Family Planning. While the Department of Family Planning allocates money for this activity,[5] the

4. *India: Family Planning Programme Since 1965*, Ministry of Health and Family Planning, April, 1969.
5. For details on this and other aspects of mass media in family planning, see Emerson Foote, *Observations and Recommendations on Mass Communication in Family Planning*, Central Family Planning Institute, New Delhi, 1969.

determination of the content of eommunieation and its actual execution is handled by the Ministry of Information and Broadcasting. Besides, supplies, transport and services are subject to the approval of the budget, grant, etc., and this leaves whatever can be classified as "technical" for the technical wing. In order to aeeelerate the family planning programme, this departmental status and thc teehnical wing were devised. But in actual practiee, the leadership of the seeretarial side of administration is pronouneed in the organizational strueture and division of functions.

Onc of the easiet ways eoneeived to translate problem into poliey and policy into administration is to create a departmental organization within the Government. The family planning programme provided an opportunity for this. Sinee the malaria eradieation programme had established the positions of regional direetors to run its programme, the Family Planning Department used this as a convenient model for its geographieal field organization. This resulted in the creation of six regional direetors under the auspiees of the Commissioner of Family Planning.

Regional Directorates

The malaria eradication programme is no example of or even parallel to family planning. It is obvious that mosquito control and conception control are two different types of problems. Yet, organizational devices used for one were duplicated for the other.

In malaria, the organizational pattern is unilateral and the regional directors have some semblance of control over the problem.[6] In family planning the role of regional directors is one of a dubious nature. At one of the seminars on administrative praetices, held in Delhi, the regional direetors who attended eould not describe their exact duties.[7]

6. For details, see Chpter III, Mass Campaign Programme, The Case of Malaria, *Health Administration and Policy Development*, Ram, N. V. R., *op. cit.*
7. Gleaned from personal attendance at this seminar.

In a subsequent discussion one of the regional directors described his functions and activities as:

(1) Rendering assistance to the States in the implementation and planning of the family planning programmes.

(2) Reviewing of family planning programmes in the States under jurisdiction periodically at State, district and rural level.

(3) Send quarterly reports to the Government of India on the progress of family planning programmes.

(4) Attend meetings of the following:
   (a) Implementation Committee;
   (b) Grants Committee;
   (c) Mass Media Co-ordination Committee;
   (d) State Family Planning Council;
   (e) Other special committees (ad hoc).

(5) Review grants-in-aid to local bodies and voluntary organizations.

(6) Co-ordination of mass media units with the State family planning bureau, the various wings of mass media being:
   (a) Films;
   (b) Information Bureau;
   (c) Song and
   (d) exhibition;
   (e) All India Radio.

(7) Organization of training programmes.

(8) Attending seminars and conferences on the family planning programme.

(9) Periodical visits to family planning programme centres.

(10) Transport procurement—health transport organizations' review.

(11) Transference of experience from one State to another.

(12) Conduct studies on important aspects of family planning.

(13) Evaluation and research.[8]

As against this list of duties, he listed his work units. This consisted of a number of committee meetings he had attended, tours he had undertaken, and the seminars and conferences he had frequented. The number, by itself, is impressive but in terms of research, evaluation and guidance to policy—or in terms of actions for programme implementation—the contribution was minimal. Yet, this position holder had the opportunity of touring many parts of the world under a programme of fellowship and sponsorship. He had also attended many international meetings and served as an adviser, observer and member of many international organizations in their deliberations.

The regional directors have neither the authority nor the resources to contribute to programme administration by virtue of their placement position and the personnel employed. In India's federal structure, States jealously guard their rights, and communication between the authorities at the Centre and in the States need not go through the regional directiors. Family planning as part of a health organization requires proliferation of health organizations. Therefore, creation of new positions and recruitment of personnel for providing health services to the people in the name of family planning becomes a possibility. From this, health services become a promised reality to the people as expressed in the election promises whereas family planning remains an ideal desire as propagated from the platform.

A State family planning officer starts with the hope that he will be there for no more than a year or two. He hopes for a transfer then, so that responsibility for the programme success or failure cannot be fixed on him. During his tenure he hopes to travel abroad, attend as many meetings as possible, and improve his position through contacts gained, as he

8. This list and a list of accomplishments were obtained from discussions and correspondence with a regional director who wishes to remain anonymous.

is aware that in status and authority he is lower than many others in the structure of medical bureaucracy. So the institution of periodic transfer ingrained in the Indian bureaucracy is a blessing for him.

The principals of regional training colleges in the States also find themselves in a situation where they can expect to benefit from being placed in that programme, before they are transferred after a year or two. There is no talent hunt to find a suitable incumbent for the position of principal; whosoever is easily available and is agreeable to a posting or a transfer is readily chosen. If this person acclimatizes to the organizational culture and atmosphere, his chances of promoting himself to a sinecure and success are great.

Programme And Promotion

In the organizational layout for family planning, programme has become secondary and promotion a primary interest of those administering it. More and more creation of one's own "cadres", "positions" and "placements" has taken precedence over achievements and results.

The normal tendency of the bureaucracy to multiply, and other features of a growing bureaucracy facilitate this development. International assistance and thinking have also contributed to this.

SIX

International Assistance

International assistance comes by way of technical consultancy services, grants for training, i.e., fellowships, travel awards and supply of materials.

The Indian Government initially requested the United Nations for technical assistance to tackle its population problem in 1950. Population, at that time, was not of much concern to the UN and the request was therefore turned over to the World Health Organization (WHO) whose opinion regarding provision of a contraceptive advice was not unanimous. Added to this, in India the Gandhian thought had always been unfavourable to the application of birth-control methods. Instead, abstinence or moral restraint was preferred. Moreover, the Minister for Health at the time was disposed towards the Gandhian approach.

Advice On Rhythm Method

WHO, however, responded by sending an adviser, Dr. Abraham Stone, to India. Stone was an American expert in planned parenthood. He advised adoption of the Rhythm Method. WHO wanted this method to be successful on a

large-scale basis as a simple method of dealing with the population problem in India

Five centres were set up—in Delhi, West Bengal and Mysore States—where the Rhythm Method was taught to some selected couples. But this method posed problems to Indians, as many couples were illiterate and had no accurate records of the menstrual cycle.

A special necklace of 28 orange and green beads, to count one bead a day, was therefore devised: the orange for the days of menstruation, and the green for the safe, non-conception days. Adjustments were made for the menstrual cycle of each woman. But very soon women complained that they could not distinguish the colour at night. Therefore, the shape of the beads was changed to round and square, the former to indicate the unsafe days and the latter the safe days. But there were other difficulties, e.g., the beads moved clockwise and also anti-clockwise; some women forgot to push the beads and the others did not want to use the beads as the whole village would know that they were practising this method of contraception. Some even mistook the beads for charmed amulets, to be simply pushed to prevent conception on any day. Above all, the biological difficulty inherent in the Rhythm Method had its final say. Since nature deviates from the statistical norm and each woman has individually a different cycle, the applicability of this method to India on a large scale was doomed to failure from the start.

Intra-Uterine Contraceptive Device

When IUCD first made its appearance in the West, its applicability to India on a mass scale was projected by many foreign consultants, advisers and experts, but no pilot study was ever made in India to test the suitability of its administration on a mass scale in Indian conditions and in the Indian political, social and economic set-up. Not a single thought was given to the managerial consequences of giving a new type of device

to the peripheral workers as an added weapon in the armoury for fighting an increasing population.

However, at higher levels in the Government, a committee headed by the Union Health and Family Planning Secretary, with three State Health Secretaries as members and the Commissioner of Family Planning as member-secretary, was constituted in 1966 to "review what additions and changes are necessary as a result of the greatly altered situation due to IUCD's having come to the forefront of the programme, in the staffing pattern, financial provision, etc".[1] This committee recommended the strengthening of the State Health Secretariats with the creation of a special cell headed by an Under Secretary, to exclusively oversee the work of family planning. Other recommendations called for more staff positions.

In all these, the main points—the capability and applicability of IUCD on an all-India basis, within the existing delivery system, and the possible consumer reaction and probable redress of consumer inconveniences—were overlooked. Some States like Haryana and Punjab took bold steps and trained their auxiliary nurse midwives in IUCD insertion techniques. In these States progress of the IUCD programme was initially greater than in the other States where the medical personnel took the exclusive responsibility of actually providing this part of the family planning services.

Although recommended by the best of foreign experts, IUCD was not the complete "technical" or "managerially feasible" answer for mass application in India's programme of family planning. The only place it was ever tested prior to its mass application was in a sophisticated modern hospital in Delhi. The clientele in this case came from an upper middle-class locality, which was least representative (or typical) of India's millions who live with insufficient medical aid, no privacy, and in different social conditions. To this extent, there were "clinical trials" and not managerial trials.

1. *Committee on Administrative and Financial Aspects of IUCD Programme 1966. Report* (mimeographed), Ministry of Health and Family Planning, Government of India, New Delhi.

Consequently, the IUCD programme which had progressed in 1965-66 and 1966-67 began to steadily decline in 1967-68. Since then, the decline has continued. IUCD trials had not been done on a mass scale, and India proved to be a good ground for this experiment. In this experiment, several factors became known : (1) non-availability of field personnel when complications suddenly arose; (2) real difficulties of adjustment for which medical attention was necessary but was not always available; (3) IUCD's applicability on a mass scale, as a programme, without sufficient pilot studies produced negative results.

Today, it is not easy to rehabilitate the IUCD programme in India simply for the reason that the clientele has lost its confidence in IUCD. Its use is declining for this reason, and rightly so. Nevertheless, the technical wing of the Department of Family Planning is still much interested in rehabilitating this programme. The secretarial wing would also be interested in it, since the IUCD factory in Kanpur[2] is producing more IUCDs than the market can absorb. At present, it appears the situation will not reverse itself in the foreseeable future.

At present, following external agencies are interested and/or involved in assistance to the population programmes in India:

1. United Nations.
2. World Bank.
3. Ford Foundation, New York.
4. United Nations Fund for Population Activities (UNFPA).
5. United Nations Educational Scientific and Cultural Organization (UNESCO).
6. The Population Council, New York.
7. The Path Finder Fund, Boston, USA.
8. International Planned Parenthood Federation.
9. Colombo Plan.

2. The factory was set up with the assistance of the Population Council, New York, foreseeing a great demand for the device

10. Food and Agriculture Organization (FAO).
11. United Nations Development Programme (UNDP).
12. World Health Organization (WHO).
13. United Nations International Children's Emergency Fund (UNICEF).
14. International Labour Organization (ILO).
15. Economic Commission for Asia and the Far East (ECAFE).

This list is not complete. It is only illustrative of the number of agencies interested in India's population problem. Various other philanthropic organizations outside the country and several nations that are interested in this problem give monetary help for many kinds of population projects.

Till 1965, the United Nations did not seriously consider population problems. They were considered as part of development and, hence, of concern to the United Nations Development Programme (UNDP).

UN Fund For Population Activities

In 1967, the United Nations Fund for Population Activities was established and was fully operative by 1970. Its responsibilities are:

1. To assist in promoting awareness of the social and economic implications of population problems and of their possible solutions;
2. To extend systematic and sustained assistance to the developing countries desiring assistance to assess and cope with their population problems;
3. To extend capabilities of the relevant organizations of the United Nations system, within the framework of their respective mandates, to provide an efficient and effective assistance to countries in planning, programming and implementing population projects;
4. To provide leadership to expanded population activities within the UN systems and to co-ordinate programming,

planning and implementation of projects supported by UNFPA.[3]

UNFPA derives its mandate from the General Assembly and its immediate hierarchical superior is UNDP. In its operation, UNFPA is a fund-distributing body and is normally expected to execute its programmes through the organization of the United Nations systems within their respective fields of competence.[4] Theoretically speaking, this has tremendous advantages. The total advantage of experience, contacts and expertise of various organizations coupled with associating or incorporating UNFPA contributions within ongoing development programmes is assured by this method of operation.

However, there are many practical difficulties. Since each body of the United Nations system has its own character and respective mandates, their total view in respect to population becomes more segmented than integrated. Therefore responsibilities of many UN organizations are varied and variable to the extent of giving a separate approach at the delivery end.[5] To cite an example, WHO views family planning as part of family health. It is a conservative organization as its approach to a great extent is medically and clinically oriented. Its outlook is also rigid in so far as it assumes the supremacy of the medical profession.

UNESCO is struggling with an educational aspect to be integrated with a well-meaning idea of "population education". This programme is just in its initial stage.

The UN concern for the population problem has resulted in a sizable bureaucracy in this field. Conferences and meetings from various angles touching upon population—from

3. *Population—The Multilateral Approach*, United Nations Fund for Population Activities, UN, New York, 1972.

4. United Nations Fund for Population Activities, *Work Plan—1972-75* (mimeographed), UNFPA, June 12, 1972.

5. For a description of varied approaches of UN Agencies, see *The UN Faces the Population Crises*, Victor-Bostrom Fund for the International Planned Parenthood Federation, Report No 15, London, Winter, 1971-72.

the point of view of education, labour, health, nutrition, etc. —have increased.

Even in national, bilateral, or other aid programmes, those who were once involved in giving "expert advice" on agriculture or rural development have become the dispensers of advice on population at relatively short notice.

Simply because funds are available, many have turned to research in a variety of population problems. From political scientists to biologists, from nutritionists to educators, all have entered this field to enrich the available published literature.

Some external assistance came by way of what is known as "institution building". Foundations and funding agencies found this a good idea and the Government of India was persuaded to create many "innovative" organizations to tackle the problem of family planning. The National Institute of Health Administration and Education (NIHAE) and the Central Family Planning Institute (CFPI)—now called the National Institute for Family Planning (NIFP)—are two examples.

CFPI-NIHAE[6]—A Case Study

In early 1962 two experts of the Ford Foundation submitted a report recommending the creation of two institutes, NIHAE and CFPI. NIHAE was created to give an innovative spirit to the field of health; CFPI was to assist in family planning research and administration.

CFPI had its beginning in the six family planning units established by the Government of India for Delhi and surrounding areas. These were: (i) Family Planning Training Centre and Oral Contraceptive Study Unit, (ii) Central Family Planning Field Unit for Delhi, (iii) Central Family Planning Communication Action Research Centre, (iv) Central Unit for

6. This section is based on personal interviews with many people involved in both the Institutes and with the officials in the Ministry of Health and Family Planning

Maintenance of Audio-Visual Equipment, (v) Mobile Family Planning Unit, and (vi) Family Planning News—publication wing. In October, 1962, the six units were amalgamated to form the Central Family Planning Institute. The institute worked as part of the Ministry of Health and Family Planning.

In March, 1965, acting upon the recommendations contained in a Ford Foundation report, the Government of India separated the Central Family Planning Institute from its departmental status and made it an autonomous body under the Registered Societies Act. However, it has all the characteristics of a Government department.

The institute (NIFP) has a General Council presided over by the Minister of Health and Family Planning to decide upon policies, provide general guidelines and consider the programme of the institute. The controlling powers lie with its executive committee, which has the Health Minister as its chairman and the Secretary to the Health Ministry as vice-chairman. The director of the institute is appointed by the executive committee; in actual practice, he is appointed by the Government of India. His selection, is subject to consideration at the highest levels.

The institute has the following nine divisions: (i) Programme Development and Evaluation, (ii) Training, (iii) Demography and Statistics, (iv) Social Research, (v) Information and Audio-Visual, (vi) Medical Education and Research, (vii) Biological Research, (viii) Population Genetics and Human Development, and (ix) Administrative Services. Each division, except the administrative services, has an advisory committee consisting of experts to advise on the technical aspects of the work to be undertaken or to review the progress of the work. These advisory committees meet to assess the research activities carried out by each division and decide if they are in conformity with the overall objectives of the programme.

In effect, the institute operates as a Government department. The executive committee meets a few times in a year and the General Council once a year. In 1971, to raise the

institute to the national level, it was renamed as the National Institute of Family Planning. The two-fold objective of NIFP is: (i) to utilize effectively the technical knowledge already existing to strengthen the national family planning movement; and (ii) to discover new knowledge and develop new methods for implementing the national programme. Since no new method of implementing the national programme is advocated or published by the institute, it is assumed that the desired objectives are yet to be fulfilled. At the initial stages and even for quite some time thereafter, several foreign consultants had been attached to NIFP to help generate new ideas for the advancement and progress of India's family planning programme.

The director of NIFP is heavily dependent on the Government of India in regard to its operations, since he has to see that any activity undertaken is clearly connected with a specific plan or an aspect of the nationwide family planning programme. As a policy this is not restrictive, however, because the director's status is dependent on the operational norms of governmental bureaucracy, and his effectiveness and efficiency are necessarily conditioned by these factors. For this reason, any contributions in the shape of a new or innovative breakthrough in research or approach have been highly influenced by these factors.

Compared with NIFP, NIHAE did not have its origin in the units previously created by the Government. NIHAE was conceived and established in 1964 as a unique institution—to explore and even discover new ways of delivering health care services to India's masses, whose capacity to bear the cost of health services is so meagre. For this purpose, NIHAE was to have experimental health districts in selected States, to demonstrate the delivery of better, comprehensive health care services through good administration and management. Better administration and management assumed allocation of resources and experimentation within the existing set of circumstances. with personnel input, new ideas and plans. Some States agreed and even carmarked funds for this scheme, known as the Intensive District Health Scheme. But, as events would have it, the disturbance on the Indian subcontinent

during 1965 pushed this scheme into the background and the fact that it has not been possible to retrieve it is partly due to the institutional incapacity of NIHAE to sell the ideas on which it was founded.

NIHAE has similar governing bodies as NIFP. The consultants who recommended this institute were attached to it as advisers and remained there for several years. Thus NIHAE gained the benefit of this expertise in the form of advice, teaching and even in policy-making. Yet NIHAE is now predominantly concentrating on training aspects. Some of the trainees who come to the courses with the hope of gaining some knowledge to apply to their difficult situations find that the content of the courses is far removed from the actual operating situations in which programmes operate.

NIHAE is also supposed to offer consultancy services to State and Central Governments. But, so far, few States have utilized its management consultancy services. As it is, one should not be surprised to find that the memorandum of association on which NIHAE is founded closely resembles the statute on which the All India Institute of Medical Sciences (AIIMS) is based—with the legal difference that the former is based on the Societies Registration Act and the latter on a Parliamentary Act. In actual practice, this is insignificant, as both are Government-oriented, controlled and directed. However, there is one difference. NIHAE has the disadvantage of having no hospital, clinic, or field practice area, whereas AIIMS is an undergraduate and post-graduate medical education institution with more than 1,000 beds and clinical services.

There are many reasons for this predicament. The conception of NIHAE as a leader in health administration with promotion of experimental districts was both ideal and practical. But, the governmental character of its status and personnel, to include the rules and regulations which govern its faculty, has reduced NIHAE to the status of a Government department.

NIHAE has the following professional divisions usually directed by a professor:

1. Epidemiology;

2. Public Health;
3. Social Sciences;
4. Extension Education;
5. Health Education;
6. Public Administration and Health Economics;
7. Statistics;
8. Programme Evaluation;
9. Hospital Administration.

The training courses conducted are mainly: (i) the two-month "Staff College" course for senior medical and non-medical administrators, and (ii) short courses in hospital administration, materials management, etc. It was only in 1972 that a course for "Training in Management for Senior Family Planning Administrators" was offered at the insistence of the Ministry of Health. The programme of this training course has minimal concentration of NIHAE, as the majority of contributors are from outside NIHAE and in many instances are heads of departmental wings.[7] This enhances the presentation of official views and bias with no forum provided for a free discussion. A climate of debate and disagreement is difficult in a teacher-trainee situation where the people involved are hierarchically well knit in superior-subordinate relationships.

The faculty of NIHAE is predominantly medical. It can be classified into three distinct types. In the first type are those who belong to the Central Government medical and health service (CGHS) and have a medical background. Those professors who are medical in background and are on deputation from CGHS are in a higher class in so far as pay and privileges are concerned; they are allowed to have a 50 per cent NPA and belong to an elevated pay status and cadre in the hierarchy of medical services. Whenever a medical administrative position falls vacant in the Central Government, either in the Directorate of Health Services of the Ministry or elsewhere, these people have a claim and consideration for promotion.

7. Programme for Training in Management for Senior Family Planning Administrators (mimeographed), Jan.-Feb., 1972, NIHAE, 1972

In fact, those who do not get promotions in their regular central health structure can aspire for positions in NIHAE or NIFP in a temporary arrangement to occupy a higher-paid position, only to be regularized later in their own regular hierarchical service and grade. Autonomous institutions like NIHAE and NIFP provide an opportunity for moving from position to position within the bureaucracy. It sounds attractive for an Assistant Director of Medical Services in the Directorate-General of Health Services to move to NIHAE for a couple of years as professor. In NIHAE most professional divisions or departments often do not have any personnel other than a professor, resulting in a one-man division or department.

In the second type are personnel deputed by State Governments. Their deputation is usually for one year, but can be extended yearly. Their NPA is 25 per cent of the basic pay, even though the duties and rank in NIHAE are comparable to those of their colleagues coming from CGHS. In view of this status, whereas the interest of those who are from CGHS is temporary, the loyalty and interest of those deputed from the States is transient.

In the third type are those who are medical or non medical in their background and whose appointment is through recruitment directly for NIHAE and are not chosen from any regularized "cadre" or "service"—Central, State or otherwise.[8] These people are paid less, have no NPA (if they are non-medical), and have nowhere to go, except to find a job in the open market. On the other hand a CGHS person such as a Professor of Public Health can hope to go to the Directorate-General of Health Services, sometimes on demand, in case he found the job of the professor not to his liking. He is guaranteed a job equivalent in rank to that which he holds in his service prior to his NIHAE appointment. The person so appointed from a State can always ask to be sent back to his home State, where his rank and service position are assured

8. "Cadre" and "service" in India refer to a set of rules and service conditions under which a person is recruited to Government service. These are rigid and permit promotion only on the basis of seniority. In the "service" and "cadre" a person can be deputed to another place and position with all the privileges maintained and rank guaranteed.

and guaranteed. The NIHAE-based person, whether medical or non-medical, has no such leverage. Additionally, he feels aggrieved that his NPA is only 25 per cent of his basic pay and not 50 per cent as is the case with his CGHS counterpart.

The directors of NIHAE and NIFP are experienced senior medical persons from Government service. They need not necessarily have an academic background. The leadership is thus assured to be of a governmental nature and tends to refer matters of decision-making to the higher levels in the Secretariat rather than taking it upon themselves or the institution.

NIHAE and NIFP have similar structures in personnel and administration. The clerical and administrative staff are deputed from the surplus capacity of the governmental wings of the administration. The usual methods of operations in the Government such as noting and routing are thus imported into a research and change-agent institution.

"Consultants", "Experts," Etc.

A UN document states that to "consult means to teach". Further, it goes on to state: "The fundamental job of the technical assistance consultant is to share and spread the benefits of his specialized knowledge in such a way that, when he completes his assignment, he will leave behind him people who are better able than they had been to cope with their problems in ways that are suited to the local situation; when a Government requests extension of the services of a consultant for an unusually long period, arguing that he is irreplaceable, it may mean that he has not done his job of training his counterparts. In fact, the duty of a good consultant is to pass on his knowledge and to cease to be necessary as soon as possible."[9] This is an ideal thing to happen. But, what happens is somewhat different.

Many consultants come from a teaching position in their home countries and lack the knowledge of local conditions.

9. *Briefing of International Consultants*, United Nations, UNDP Document 26922, Nov., 1967, p. 7.

They hope to gain it during the course of their consultancy assignments abroad. Many consultants learn the problems and conditions and write books on their return to their own countries.

At one time, in India, there were 17 consultants from a private foundation advising the Ministry of Health on family planning. Adding up the number of consultants from other foundations and countries giving bilateral assistance, the number was nearly 40. In most cases, consultants had no knowledge of the complex background of the programmes.

As a foreigner and a guest, a consultant is in a privileged position. Normally, a civil servant who would hesitate to give an interview or discuss data with an Indian scholar would go out of his way to co-operate with a foreign consultant. This advantage ensures the consultant access to such data on the programme as is not readily available to an Indian scholar. Besides, an Indian scholar or a professor does not have the financial resources to collect countrywide data, nor can he make a trip to Delhi whenever he pleases. A consultant, being amply paid in comparison to his Indian research counterpart, has all the advantages when working in an underdeveloped country. He is well received, can travel where he wants to, and seek and obtain interviews. As a result, a consultant will more often be producing a work of "authority" on the subject of his consultancy (either during his tenure or immediately after his tenure in the country is over). This practice is so rampant that the head of a division in a State had given specific instructions to his public relations officer to see that no consultant or visiting scholar received casual interviews with the villagers or administered a questionnaire. He was concerned that these casual interviews would eventually be published as authoritative reference sources in book form.

If the consultants are attached to an institution or a Government department, they usually have a "counterpart", who is an executive with authority, seeking "ideas" from the consultants. In the majority of instances, consultants are prone to dabble in the administrative details of the programme instead of generating ideas. For instance, they would like

to ensure that in the recruitment of personnel, Indian or other students studying in their home institution are preferred. They would often pursue this to the end result to have a particular person selected. In one case, the role of the consultant in the selection of a particular person was so obvious that, to the embarrassment of the head of the department, the person selected was corresponding with the consultant regarding his probable date of availability and arrival in India. In a departmental meeting, when a colleague asked as to when this selected person would be available, the head of the department passed on this question to the consultant with a remark that "Dr. X knows, since he does not correspond with me." In a situation like this, this particular person having the full support of this consultant formed, with others similarly placed, a special group within the department. As a result, there was a "faction" of those on the consultant's side and of those who were out of it. In this specific instance mentioned here,[10] the head of the department wisely joined the consultant's faction and carried out his decisions in conformity with this group's advice. The result was an alienation of other Indian expertise to the detriment of the institution and the programme, but to the benefit of the faction. The faction benefited, as their access to international meetings and conferences increased. They also benefited in so far as the reports to the Government showed them to be the "productive" people in the field.

In many cases, it is profitable for the "counterpart" to "play on the side" of the consultant. In this way, the "counterpart" can build his own group of supporters, get favourable reports passed on to his superiors about his organization, and provide himself with an opportunity for further assignments through contacts with consultants. Trips to foreign countries and short-study tours to important places are other advantages to be gained during the active period of good relations between the "counterpart" and the "consultant".

Consultants, by virtue of their nearness to policy-making executives, become influential. They can contribute suggestions

10. This section is based on interviews with various persons and study of a consultancy situation for over four years.

at the right source of decision-making and have top executive decisions passed or reversed.

Many consultants do not live by Indian standards of comfort. They prefer a chauffeur-driven car, a cook, a maid, a gardener, and a host of servants, though they cannot afford all this in their own affluent societies. With these facilities they tend to project a super-affluent image of themselves. It can be assumed that some of them deliberately show off their affluence. Consequently a situation develops wherein a consultant's disciples become his intellectual slaves. But others who resent this ostentation do not accept him as their intellectual equal, especially when they become aware of the limitations of his competence. And the dislike is complete when the consultant's operations are less intellectual and more personal. An estrangement soon follows. This creates an awareness in the keen, questioning mind of the local researcher "counterpart" or "professor". Simply stated, he wonders, "What is the return for the $30,000 a year which is being paid to this consultant and accounted as an aid to my country?"

This estrangement has existed in India for some years now. Of late, accelerated by other factors, it has become complete and total in its context and concern. The contribution of consultants to the solution of problems has been minimal, but their own situational advantages have been maximum, and they have not always worked for the benefit of programme administration.

Having experimented and conducted a gigantic programme of family planning, India now does not need technical assistance of any great magnitude for its family planning programme. It has lessons to offer in this field. The problem is one of demand creation for family planning in India rather than supply and delivery. No ideas for this can come from "consultants" and "experts" whose knowledge of the field is recent or at best armchair. In regard to financial assistance, the problem is one of absorbing the resources allocated, rather than of finding allocations for expenditure; this is amply evidenced by the allocations unspent.

Fellowships and travel awards serve a limited purpose. Their intent, purpose, seleetion methods and utility ean be subjeeted to mueh scrutiny. Suffice it to say, India now needs "Indian solutions to Indian problems". India has to manage its population, and this raises the question: Can we manage the present population along with the fertility eontrol programmes already launehed?

SEVEN

Population Management

Managing people in a democratic framework has its own problems. It is not a game of numbers but the number of people to be managed has a great bearing on the type of leadership which may emerge and the stability and progress of the institution created for the management and progressive development of people. This aspect of population is wider in scope, larger in context, and is closely related to the progress of family planning. But unfortunately, it is on this facet of the problem that relatively little emphasis has been laid, and a systematic contextual relationship or programme has not evolved, in spite of our efforts in planning and development administration.

The closest we ever came to linking the problem of population management to the progress of family planning is the realization that growing numbers will have growing needs to be fulfilled. It is expressed as resources required for the 13 million added to each year's population. It is estimated that this will require:[1]

126,500 schools;

372,500 school-teachers;

1. *Population Problems of India*, Department of Family Planning, Government of India, 1967, p. 17.

2,509,000 houses;
188,774,000 metres of cloth;
12,565,300 quintals of food;
4,000,000 jobs.

These basic essentials are well enunciated in the Directive Principles of State Policy and are elaborated in the Indian Constitution. The Directive Principles lay down that the State shall strive for:

A social order that ensures justice, social, economic and political;
Promotion of welfare of the people;
Provision of adequate means of livelihood;
Extension of adequate protection and aid to the handicapped and promotion of the welfare of the weaker sections of the population;
Provision of compulsory education to all children;
Raising the level of nutrition and the standard of living of its people; and
Improvement of public health.

A control on the size of population has a direct relationship to the achievement of the above Directive Principles, in so far as the time in which these tasks are designed to be achieved is concerned.

In administering programmes of economic and social development, the size, distribution, composition, literacy levels, employment, movement, health, morbidity levels and, above all, growth rate are of primary consideration. The programme of population control that has been launched upon takes only the growth-rate into consideration. Motivations for family planning, based on health, welfare and monetary incentive considerations, do not arrange themselves in conformity with the programmes of growth and development, either directly or indirectly.

Education

Take, for example, the field of education. This is a biggest industry in India. With a phenomenal growth in the number

of higher educational institutions, i.e., colleges and universities, the struggle has been for quantity versus quality. Whereas this work does not engage itself in this aspect, it is safe to go along with the critics that the quality has come to be regarded as secondary in a mass system of education where the stamp of a university degree is considered essential for many types of jobs as a minimal entrance ticket. Yet, the need and challenge for India's population does not seem to be in this higher-level education, in terms of fulfilling the Directive Principles of State Policy.

Given all the resources we can possibly spend, India's masses can, at best, hope to receive a primary-high-school education. This also means that the need for good education is at the primary through high-school level and not at the college level. Also, given the level of literacy today, 30% (1971), and the opportunities that are being made at this level, India has to face the fact that most Indians will not go beyond the secondary-school level. In other words the primary school education is not expanding at a rate at which it can cover all the children who are likely to go to school. This is evident from the fact that with all the expansion of education from the year 1961 onwards, literacy rate has risen only by about 6% (1961—24%). The middle-class pressure in towns and cities has created more colleges and universities, depriving the opportunity for literacy and, through literacy, an understanding for true education in life for the majority of Indian citizens who live in 550,000 villages. Inasmuch as basic education for family planning can be started at the primary- and secondary-school levels, the argument for primary and secondary education for all, before college education for some, is a realistic approach to a meaningful population policy and programme.

The present primary to secondary-and high-school level education does not prepare Indian youths to live in and enrich their villages, nor does it prepare them to lead a better life. Therefore, before attacking the problem of education at the college level, priority in the population policy should be given to the development as well as reform of education at school level in order to build a sound and solid base.

Public Health

Like education, health is a State subject except for items such as international quarantine, legislation regarding food adulteration, port health and prevention of intra-State spread of communicable or contagious diseases. As a developmental subject-matter coming under the States, the interest of the Central Government is manifested in sponsored schemes coming under the Five Year Plans.

Control of communicable diseases took a place of primary importance at the Centre. Other important programmes include post-graduate medical education, development of higher education in the Indian system of medicine and medical research.

Malaria, smallpox and tuberculosis are the major problems of public health in India. The National Malaria Eradication Programme was launched in 1958. It was conceived to eradicate the disease and consisted of four phases, i.e., preparatory, attack, consolidation and maintenance. The ultimate objective of eradicating the disease and entering a maintenance phase was fixed for 1968. However, this could not be achieved due to various administrative and managerial gaps. Several malaria control units have reverted from the consolidation and maintenance phase to the attack phase and recent reports indicate an increase in the number of cases. In 1961, 49,151 cases of malaria were detected, whereas in 1965 and 1967, 148,156 and 201,369 respectively were reported.[2] In 1970 and 1971 the number of cases rose again, causing many malaria units to revert to the attack phase. The setback has been due to laxity in or ineptness of the operation, and logistical difficulties in making a timely supply of insecticides. The vertical organizational machinery which came into being exclusively to carry through this programme found itself placed in the health organization with adjustments made for its integration with the health set-up.

A similar fate met the smallpox eradication programme. An effective coverage of the population has not been possible,

2. Data from the Annual Report of the Ministry of Health.

even though the programme has been in operation since 1963 and the whole country was expected to enter the maintenance phase in 1968.

Compared to the two programmes discussed above, the tuberculosis campaign has made some progress, but it is difficult to say with certainty what the impact of this programme has been on the prevention of this disease.

Basic to the consideration of the problem of public health is sanitation and water supply. The actual position with regard to protected water supply, even in urban areas, is not known. It is estimated that about 70% of the urban population has some sort of protected water supply The Second, Third and Fourth Five Year Plans provided funds for safe-water supply to towns and villages. The implementation lay in the authority of the States. Whether this aspect is directly linked with the administration of public health services is another question. This has been dependent upon the set-up of the local Government and the interest and involvement of leaders both in the local Government and public health.

The basis of public health policy in India is the report of the Health Survey and Planning Committee of 1961, also called the Mudaliar Committee Report. This document made an assessment and submitted a set of long- and short-term recommendations. As events since 1961 have proved, some of the recommendations are unattainable as they were placed at an unrealistic level and some have no relevance in the changed conditions. For example, the attainment of so many beds per thousand population, by itself, is not a measure of improvement in health services. In the same way, an improvement in the doctor-patient ratio is also not a guarantee of better public health as can be seen from the non-absorbable availability of doctors. This is due, as previously mentioned, to the increase in the number of medical schools from 57 in 1961 to 100 in 1971. This means a reappraisal of public health policy is required on a Statewide basis taking into consideration the population characteristics, the types of diseases, and the services required. On this basis, the problems can be linked to a manageable proportion to be solved and

services delivered to the people. A Primary Health Centre will then be able to have a meaningful public health programme linked to water supply and sanitation. This is one aspect which has much direct connection with public health and yet it has now so remote a managerial programme linkage.

Manpower and Employment

The labour force of India for the next 10 years is already born and no matter what we do in the field of family planning, this cannot be altered. In 1971 it was estimated at 201 million and it is expected to reach an estimated 263 million by 1981, of which the rural labour force will constitute 214 million. This requires creation of extensive employment opportunities and checking of rural labour migration to congested urban areas. Vocational guidance services and provision of employment market information for this purpose need top priority.

Basic information on the different characteristics of labour force and on the relationship between education, employment, income and development is now being collected at the State and national levels. This requires not only regular and periodic collection but also an analysis for manpower policy, from district to State and from State to national levels. Location of industries, subsidies to establish employment potential enterprises and such other related measures can be successfully manipulated for better utilization of manpower.

These are economic and social developmental issues which relate to population. Integration of economic, social and political development aspects with the programmes of family planning is a compulsive corollary for the success of any population programme. Family planning alone does not contribute to population stabilization and much less to economic development. This is not a place to establish the interlinking influences on which the success of family planning programmes is to be based, nor is this a place to describe the economic, social and political developmental forces which go along with family planning to bring about a population stabilization. But a realistic assessment of the working of the economic, political and social forces which surround a family planning

programme should serve as an objective guideline for reasonable achievements with the family planning organization as an instrument of population control policy.

Current projections of the United Nations foresee a net reproduction rate of 1.0 to be attained around the year 2045. At this time, world population is supposed to level off at 14.7 billion.[2] From this standpoint and from our experience, it is obvious that no matter what we do, we cannot reduce our total population in the near future; we can only attempt a slow rate of growth and for so doing, we have to stabilize population, establishing linkages with other developmental programmes. Therefore, we have to estimate programme achievements for the national development to foresee what is achievable. This is a very important factor in view of the fact that in a given social and political set-up, optimization of family planning programme results is limited and determined to a certain extent. On this basis we have to consider different levels of birth-rate and family planning achievement in different States. The strategy, objectives and options will then require a redefinition. In doing so, socio-economic and political development indicators are to be interwoven with the family planning programme. To achieve this, the machinery now designed for family planning requires reorganization.

Whereas no specific or detailed recommendation for reorganization is attempted here, major points and issues in a general context are considered in the following chapter.

2. UNFPA—*Work Plan 1972—1975* (mimeographed), New York, 1972.

EIGHT

Resume And Results

This section deals with the essential aspects of the family planning system in general and as it is being managed in India in particular. The attempt here is also to see the ramifications of this subject matter of population as it has affected the thinking and action trends of those concerned with the management of family planning. This includes the national as well as the international level.

Subsystems

India's family planning is a subsystem of her health system and has itself many subsystems. In order to give an idea of the various subsystems which exist, a description of a few is essential.

Manpower Subsystem: With the adoption of the "extension approach" as against the "clinic approach" the demand for an additional number of personnel increased. The Government of India has fixed at 156,000 the number of technical personnel required for the family planning programme. At present about 100,000 persons are employed. These personnel are spread over Central Government, State, and district family planning bureaus, training institutes and, at the local level, the primary family welfare planning centres. They are at

once part of general governmental bureaucracy as well as the health bureaucracy. Whether this subsystem contributes optimally to the total performance objectives of the family planning system is another question. The temporary nature of the appointments of various categories of personnel and some other difficulties have been dealt with in the reports of various committees, including a report of a United Nations team of experts.[1]

Training Subsystem: This has become a huge establishment with 46 State and five Central training institutes. There are training programmes for various categories of personnel, but training in programme management is lacking. Training courses with a semblance of management are not directed at those levels where they could be most useful. Also, there is no top-level training of the executive development type for the family planning managers. It has been admitted at high levels that the strategy for training is *ad hoc*.[2]

Communication Subsystem: This is a peculiar arrangement of the Department of Family Planning with the Ministry of Information and Broadcasting. From the point of view of achieving the desired results, this subsystem needs a redefinition of objectives and strategy.

Information Subsystem: This requires improvement and development. At present, there is no rapid feedback of data on programme progress and a control mechanism to rectify deviations in the path.

Data obtained in 1970 on the above subsystems and some suggestions for improving each of them are given in Appendix IV. However, these are relevant and applicable only in the overall context of managing a population problem linked to economic, social and political development. This aspect has been taken into consideration and broad suggestions and observations have been made.

1. United Nations, *An Evaluation of the Family Planning Programme in India*, New York, 1967.

2. S. S. Rao, *Development of Human Resources and Training for India's Family Planning Programme* (mimeographed), New Delhi (undated).

Viable System of Family Planning Management

The following points emerge as some possibilities for developing a system of family planning administration in the light of the discussion bringing out the difficulties of the existing system. Some of the conclusions are in the nature of general observations in the global context of population control. Since population has become an international issue, the programme implications cannot escape the interest and influence of foreign agencies. In so far as these issues affect the management of the programme, these observations are directly related.

1. A primary health centre is now not a viable unit of the health administration. As a unit covering a population ranging between 80,000 and 100,000, the physician-chief is not a managerial physician. This raises two possible solutions:

(a) to render the primary health centre a manageable unit by limiting the coverage of the number of people; and

(b) to train the medical doctor to be the manager of this unit.

2. To train the medical doctor to become manager-physician cannot be achieved in isolation. This is possible only through reformation in the medical education.

3. This reformation should take a thorough stock of the non-systemic imbalance prevailing in India's medical education system, and formulate a policy which should provide for the incorporation of family planning management as a speciality in medical education. Otherwise, merely the opening of more medical colleges will not serve any purpose. With a 23% shortage of teachers in the existing medical colleges, the quality of medical education is bound to deteriorate.[3]

4. The above situation calls for consideration of two courses of action open to us. First, to revive the licentiate

3. See, *Demand for Doctors for Fourth and Fifth Plan Periods*, Institute of Applied Manpower Research, New Delhi, 1969.

diploma in medical education and, second, to demedicalize family planning. Producing "one type of good doctor" in the country as a whole was one reason for dispensing with the licentiates; another was to provide an internationally acceptable doctor for India. But the present medical education system does not indicate attainment of this goal; there does not appear to be "one type of good doctor" available throughout India, and international acceptability of the Indian physician at present is dubious though good Indian doctors have found themselves internationally acceptable. In the circumstances, therefore, revival of licentiate course seems to be the only logical alternative. Otherwise, just as water finds its own level, bachelors of medicine will find themselves sliding down to the level of licentiates, particularly in view of the shortage of teachers and the indiscriminate increase in the number of medical colleges. To quote Dr. A. L. Mudaliar:

> "We regret to note that in their anxiety to open more medical colleges and with a view to satisfying the demands of the public, State Governments have unfortunately not always considered all aspects of the question and have precipitately opened medical colleges with insufficient staff and inadequate accommodations and in many cases without proper equipment also."[4]

5. Demedicalization of family planning, as suggested above, should be undertaken immediately to accelerate the progress of the achievements of the family planning programme. This means only those doctors who are interested in family planning management should be in the managerial level of the programme. This would also mean that those not interested will naturally become technicians, rendering services like sterilization, advice, etc. The acquiring of knowledge and expertise in techniques does not make a person a natural claimant for its management. This should be realized by all professions including the medical profession.

4. *Background paper for the first meeting of the subgroup on Manpower of the Planning Commission on Employment and Training* (mimeographed), Directorate of Manpower, New Delhi, 1970.

6. Demedicalization of family planning management also entails careful selection of medical managers and trainers. Physicians not interested in this type of work should be excluded from the programme. A provision should be made to select those medical men who are interested in family planning management and keep them for a period of five years in family planning. Their performance should be noted for the purpose of their service records. Some knowledgeable sources suspect that this method would result in a sharp decline in those opting for family planning management. If so, selection of managers for the programme should be further examined and suitably revised to attract the right talent, even though this may mean recruitment from outside the field of medical profession.

7. Family planning involves serious programme management with extensive social, political and economic implications. It is not the prerogative of any one profession and much less of those who want to find positions when sandwiched between the claims and prerogatives vested in civil service rules governing public health and clinical sides of the medical profession.

8. A health administrator's claim for family planning management is corroded by his lack of programme achievement as an executive and manager. Whatever the reasons for this, the fact remains that it needs to be re-established, especially in view of the recent massive camps in Ernakulam and elsewhere.

9. The Ernakulam camp marked the beginning of a new trend which provides useful guidance. When family planning performance was lagging in Kerala, the District Collector of Ernakulam made a proposal to the Centre for conducting a mass vasectomy camp under his leadership and control, based on higher incentives. At the first camp held in November-December, 1970, 15,005 persons were sterilized. Encouraged by this, a second camp was held in July, 1971. In this camp

over 62,000 persons were sterilized.[5] Two-thirds of these were non-residents of Ernakulam. Apart from the fact that this camp was conducted as an "experiment" and as part of district developmental activity, the main reasons for the success of this approach have been:

(a) efforts of a dynamic manager:

(b) total coverage of the population by better organization and management;

(c) motivation and incentives related to response;

(d) acceptance by groups; and

(e) an effort on the part of all Government agencies plus the industry and business.

One can see the same elements or a mixture of them in a greater or lesser degree wherever in India programme achievement of family planning has been rated as high. Obvious examples which readily come to mind are the Bombay Experiment,[6] Assam Tea Gardens and the efforts of some industrial establishments including Tata Nagar.

10. This "experiment" and several similar attempts have yielded rather successful results[7] and raised the question regarding the utility of an elaborately constructed continuing and increasing infrastructure for providing family planning services in India.

5. For the full report see S. Krishnakumar, *The Story of Ernakulam Experiment in Family Planning*, obtainable from the Financial Assistant to the District Collector, Ernakulam, Cochin, Kerala State, India, 1971. Also see Veena Soni, *The Ernakulam Camps*, Ford Foundation, New Delhi, 1971.

6. For details of the success story of the family planning programme in metropolitan Bombay, see D. N. Pai, *War for Survival*, Municipal Printing Press, Bombay, 1971.

7. Ernakulam-type mass sterilization camps were repeated with an accent on higher incentives in Bulandshahr district, U. P., all the 19 districts of Gujarat State, and in Gurgaon district, Haryana State. They have not been as successful as Ernakulam for various organizational, managerial and other reasons.

11. By taking a closer look at the system of family planning services in India and comparing the results achieved, it can easily be concluded that the system is top heavy, and ill-designed for an efficient programme management. A thorough organizational analysis from the Central level to the local level is, therefore, imperative at this stage of the programme development. Otherwise, the system, as it is growing at present, will at one stage be beyond recognition, for the purpose of pinpointing programme responsibilities.

12. As it is, no one at the Centre is responsible for programme success and achievement. The Ministry of Health and Family Planning, compared to the Ministry of Finance, Industry or Home Affairs, is perceived to be less important. Health is a secondary issue in any country. This has happened to family planning in its association with health. Since control capability is not resting with the Ministry of Health and Family Planning or its subordinate, the Department of Family Planning, the function as performed by the Central Government now is one of a financial controller and not of a planner of strategy and alternatives. Even in financial matters, since there is no way of overseeing that appropriations for family planning are not surreptitiously spent on health matters, a good measure of acceptance of family planning by the States can be attributed to the possibilities of creation of assets for their health departments.

13. Therefore, there is a primary need to fix the responsibility for programme achievement on an agency other than the combined Ministry of Health and Family Planning. This needs an organizational innovation, depending on the way local needs for economic, social and political development are designed and planned. If the States view it as part of their developmental programme and conceive it the best way to achieve it, for example, through the District Collector's leadership and responsibility, the pattern of organization at the top and at the State Secretariat will have to be suitably modified.

14. Family planning enterprise in India has obviously more finances than it can spend. In the year 1970-71, only 37.3% of the apportioned amount could be spent. But the expenditure

has been mounting since the beginning of the Fourth Plan without much indication of a proportionate increase in the physical performances. This should be gone into, and remodelling of this enterprise along sound management principles seriously considered. Further, in the face of an increase in the capital expenditure on construction activities and vehicles since 1969-70, the programme performance in terms of equivalent sterilizations has been going down.[8] This trend towards a negative balance-sheet has to be arrested.

15. However much we may desire to implement methods "Beyond Family Planning",[9] many of these are impossible in terms of economic and administrative feasibility. It is therefore best to be modest about what can be achieved, and as such targets will have to be realistic. From this, it is safe to assume that no matter what we do the population is going to increase at a certain rate and the employing of more people for the population control machinery is useless. In fact, one of the problems in India's population control programme is the excessive number of people employed in the extension of their own discipline or subject-matter interest. We simply have to plan for an increased population with a decreased population bureaucracy and programme finances, so that resources could be diverted to other needed developmental programmes.

16. A similar situation exists at the international level. The field of population control seems to be overpopulated. In the USA alone there are more than 40 population centres, each attached to a university doing research on population. Besides, a number of university departments, medical schools and schools of public health are engaged in population research or population related research. The USA has no population policy at present and the programme of population control is operated by voluntary bodies with a Government subsidy mainly to indigent

8. As quoted in *India's Family Planning Programme—Mid Plan Appraisal* (mimeographed), Department of Family Planning, New Delhi, April, 1972.

9. B. Berelson, *Beyond Family Planning*, Studies in Family Planning, Population Council, No. 28, February, 1969.

persons. Therefore, the impact and concern of these centres of research are minimal for the USA itself and focus largely on the problems in other countries. This concern can be said to be part of an extension of the welfare concept to the international sphere. But it is largely due to availability of funds in this area for research, teaching and consultancy.

17. Lacking any knowledge of the managerial aspects as well as local conditions of the clientele or overseas situations, this phenomenal growth of population centres has facilitated the exportation of experts and consultants. In many cases, such consultants, often rejected in their own universities for various reasons, become "concept peddlers" in a foreign land. Concepts may be valid within the framework of the consultants' home country but not always in a situation in other countries. This factor, coupled with various reasons already discussed, has made these "concept peddlers" an unpopular commodity. In India, with its own rich experience of running a gigantic programme and with all the expertise available within the country, the need for foreign consultancy is minimal. What is required is utilization of Indian talent for Indian needs and Indian solution for Indian problems.

18. Population research centres outside India can do well to interest their Indian counterparts and pass on any research design that they may have to them. If the scheme is interesting and worth while, it should be left to Indian initiation. Very often research schemes designed abroad are carried through in India, either independently or in collaboration with an Indian institution. The collaboration is relatively less Indian and more foreign in content. The content from abroad would be in terms of money, interest and objectives as well as the source of inspiration. Such research schemes often serve little purpose for the management side of the programme. Their utility in application to make a policy impact is bound to be limited. In such circumstances it will only serve as an additional volume in the growing literature on population on the shelves of libraries.

While we are on the subject of research from outside agencies, it occurs that it may be useful in the collaborative

process to have some Asian scholars work on US and other advanced countries' problems of population, health and related matters. This approach would help wipe out what seems to be an implicit understanding that the advanced countries, particularly the USA, are always teachers and others learners. The field of population is no exception.

19. Research on population has become a big business. From national to international level, money is funnelled on various counts to the research schemes of different institutions. But the time has come to ask for and assess the results of the research. In other words, we need to do some research on research already done in population in relation to what use it has been put to or what useful purpose it has served. However, it is no use duplicating the kind of research done in the case of knowledge, aptitude and practice (KAP) studies and discover that its applicability in reality is dubious.

20. In the Indian scene, though a number of demographic, KAP and other studies have been carried out by research centres and universities as well as the National Sample Survey, these are not co-ordinated enough to obtain a meaningful picture of a programme process in the entire country. One assumes NIFP or NIHAE would have done this. But for reasons discussed in the foregoing chapter these institutions have fallen short of the expectations[10]. It is time some of these institutes are reorganized.

21. Like research, training in this field is also a big business. Many training programmes conducted internationally are far removed from the reality of the situation. These forums often talk glibly and get a "warm up" attitude towards better programme management. But in the absence of any "follow up" the effect soon wears off.

22. There are too many conferences, seminars, workshops and symposiums in the field of family planning. A small

10. The one futile attempt made in this direction can be seen in *Studies in Family Planning in India—A Review for Programme Implications* (mimeographed), Central Family Planning Institute, no date. This work attempts to list KAP-type studies.

research project on cost benefit analysis would certainly show that many man-hours are lost in these conferences, besides indirectly indicating the amount of time the attending personnel can afford to be away from their job and the non-usefully spent working hours of the population bureaucracy, nationally as well as internationally.

23. International conferences are no exception. These forums serve the specific purpose of contacts and exchange of experience if they are planned and conducted purposefully; otherwise, they will serve as the meeting place of the same people with a lot of general talk on items already discussed in other similar conferences. Therefore, all international meetings, training programmes and conferences need be carefully thought out and planned for in order to achieve a specific set of objectives.

24. International aid also follows a similar pattern. Apart from the UN and a host of UN-related agencies, private foundations, universities and other centres have increasingly and readily delved into this area, through funds for research, consultancy and projects of interest. As for the UN, its interest is legitimized through its mandate. How the mandate gets executed is another question and is discussed elsewhere. Suffice it to say that a reconsideration of its effectiveness is now needed.

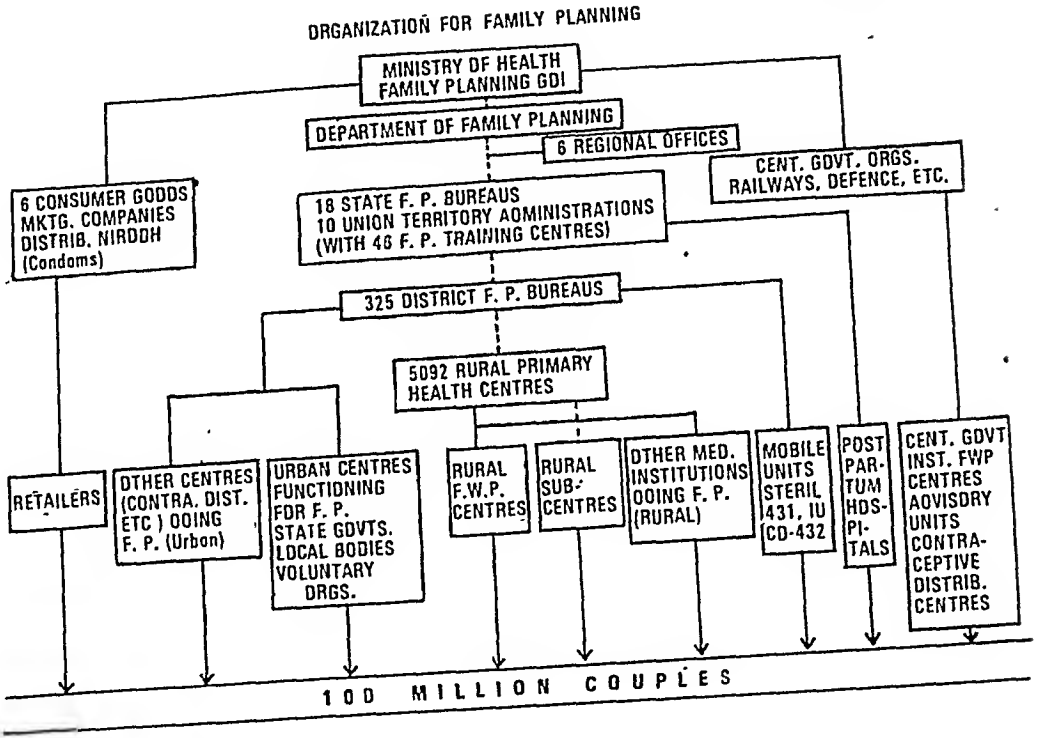
As for other agencies, it is high time they paused and asked themselves what is in this for themselves. The age of altruism is receding into an era of self-seeking. They must also see what the recipient countries accepted. New ideas in this area should result in a more realistic approach to this problem by asking themselves: What is the cost-effectiveness ratio? Is it a method to have population centre corporations going on, or is it a policy-influencing instrument? An academic inquiry into this will give a reappraisal which would help in the formulation of a new set of goals and policies most useful and desirable at this juncture.

25. That there is a serious population problem, is not denied but the way it is being managed nationally and internationally seems to indicate that population has become a

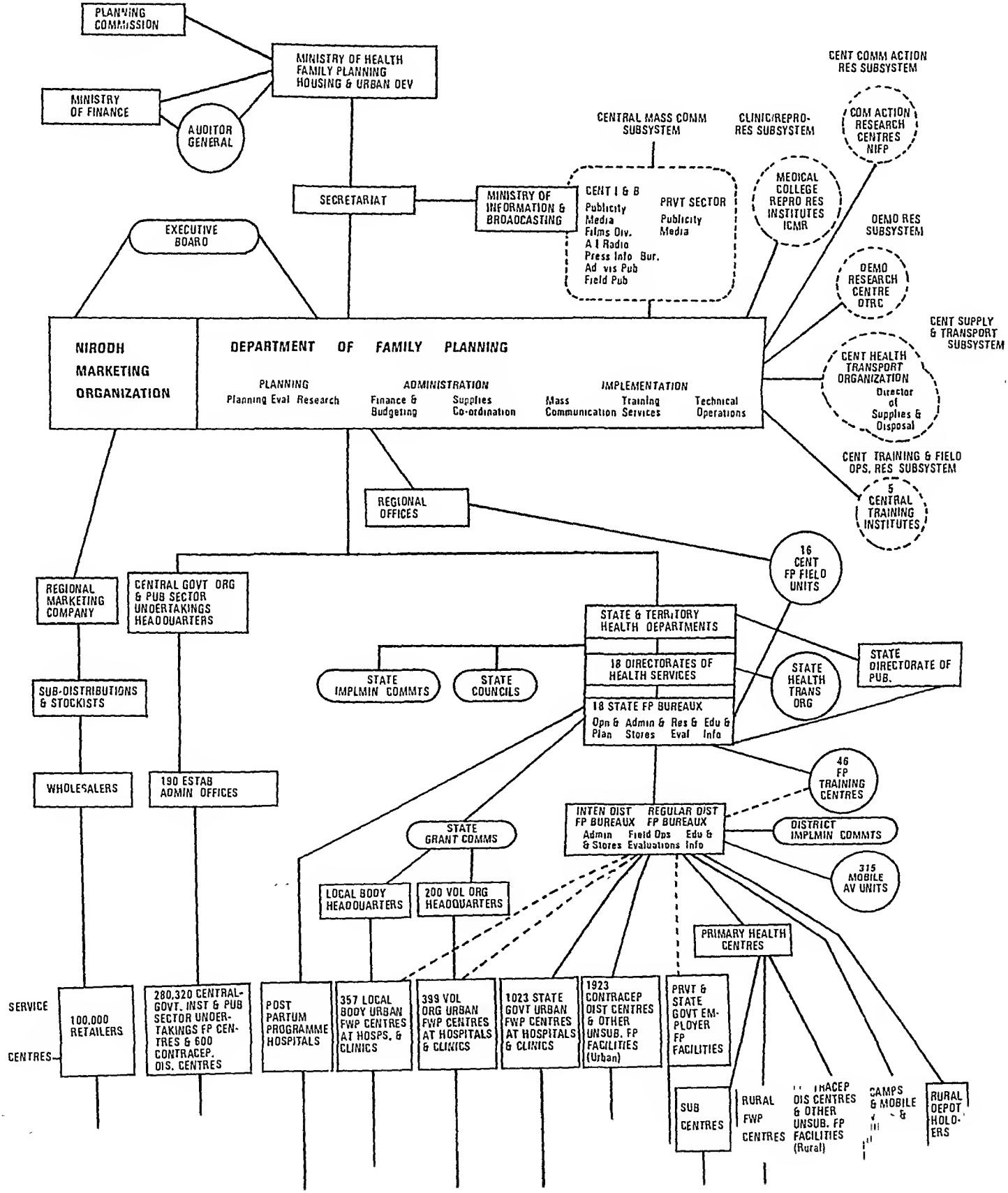
shibboleth of this age. Not long ago, it was food and agriculture, tomorrow it may be environment and ecotactics. In this age of pressurized articulation of ideas, a conception of managing the problem in the total context of a set of situations and limitations is forgotten. Added to this, international intellectual opinion and money have easily lent themselves for the creation of positions, departments, agencies and high-level conferences, all leading to a gigantic research-oriented, group-concentrated, bureaucratic-intellectual complex. Population programme managers who really care to manage this problem have a stupendous task of managing population and the population bureaucracy.

If the above are debatable and debated, the subject matter of management and population has deserved emphasis and consideration in a world where much stress has been laid on demography, numbers and medicine management.

APPENDIX I


ORGANIZATION FOR FAMILY PLANNING
MINISTRY OF HEALTH FAMILY PLANNING GOI
DEPARTMENT OF FAMILY PLANNING
6 REGIONAL OFFICES
6 CONSUMER GOODS MKTG. COMPANIES DISTRIB. NIRODH (Condoms)
18 STATE F. P. BUREAUS 10 UNION TERRITORY ADMINISTRATIONS (WITH 46 F. P. TRAINING CENTRES)
CENT. GOVT. ORGS. RAILWAYS, DEFENCE, ETC.
325 DISTRICT F. P. BUREAUS
5092 RURAL PRIMARY HEALTH CENTRES
RETAILERS
OTHER CENTRES (CONTRA. DIST. ETC) DOING F. P. (Urban)
URBAN CENTRES FUNCTIONING FOR F. P. STATE GOVTS. LOCAL BODIES VOLUNTARY ORGS.
RURAL F.W.P. CENTRES
RURAL SUB-CENTRES
OTHER MED. INSTITUTIONS DOING F. P. (RURAL)
MOBILE UNITS STERIL 431, IUCD-432
POST PARTUM HOSPITALS
CENT. GOVT INST. FWP CENTRES ADVISORY UNITS CONTRACEPTIVE DISTRIB. CENTRES
100 MILLION COUPLES

FAMILY PLANNING SYSTEM.



[Estimated Birth-Rate of Different States and Union Territories of India—1971*]

Sl. No.	State/Union Territory	Estimated Birth-Rate
1.	Andhra Pradesh	37.3
2.	Assam	47.6
3.	Bihar	40.3
4.	Gujarat	42.5
5.	Haryana	NA
6.	Jammu & Kashmir	NA
7.	Kerala	36.6
8.	Madhya Pradesh	39.5
9.	Tamil Nadu	32.6
10.	Maharashtra	38.0
11.	Mysore	39.1
12.	Nagaland	NA
13.	Orissa	37.9
14.	Punjab	42.1
15.	Rajasthan	39.9
16.	Uttar Pradesh	38.8
17.	West Bengal	40.8
18.	Andaman & Nicobar Islands	NA
19.	Chandigarh	NA
20.	Dadar & Nagar Haveli	NA
21.	Delhi	NA
22.	Goa, Daman and Diu	NA
23.	Himachal Pradesh	NA
24.	Laccadive, Minicoy & Amindivi Islands	NA
25.	Manipur	NA
26.	North-East Frontier Ageney	NA
27.	Pondicherry	NA
28.	Tripura	NA
	ALL INDIA	38.6

**Family Planning in India, Programme Information 1970-71*, Ministry of Health and Family Planning, New Delhi, 1970. [NA: Not Available.]

APPENDIX IV[1]

[*A Note on Subsystems within India's Family Planning System*]

This appendix contains information and data regarding the various subsystems within India's total system of family planning. Observations are presented with suggestions for the improvement of each subsystem. However, these suggestions are to be viewed in the context of their contribution to the performance objectives of the total system. In this manner they are to be closely examined with reference to the observations in the chapter entitled Resume and Results.

Manpower Subsystem

With the adoption of the "extension approach" rather than the "clinic approach" the demand for additional personnel for the family planning programme has increased. The Government of India has fixed the number of technical personnel needed at 156,000 but at present only about 100,000 persons are employed in the programme.

All five central training institutes as well as the National Institute of Health Administration and Education, New Delhi, and the Demographic Training and Research Centre, Bombay, are managed by central personnel.

State Personnel: State bureaus administer the family planning programme at the State level The following table[2] indicates the medical and non-medical manpower situation at the State level as estimated in early 1970.

Total No. of persons required	Total No. of persons sanctioned	Total No. of persons in position
144	126	100 (69%)

1. The data given in this section are collected by the author from different offeers of the Ministry of Health and Family Planning.

2. The categorles of personnel ineluded in the sample group listed in the above table are : State Family Planning Officer, Deputy Assistant Direetor, Administrative Officer, Medical Officer/IUCD, Health Education Officer, Statistieian, Store Officer, Assistant Editor.

There are demographic cells attached to the State bureaus of family planning. Most of these cells are well staffed.

There are also 44 out of 46 regional (State) training centres. The following table indicates the staff position in these centres:[3]

No. of persons required	No. of persons sanctioned	No. of persons in position	No. of persons trained	No. of persons untrained
460	390	303	202	101

Central family planning field units (CFPFU) also operate, technically, under the States. The following table gives their staff position:[4]

No. of persons required	No. of persons in position	No. of persons trained	No. of persons untrained
88	72	65	7

District Personnel: At the district level there is a district family planning bureau which is the operational unit of the programme. Of the 327 district bureaus required, only 318 are in operation. There are mobile units with these bureaus to provide sterilization and IUCD services. These units have a doctor, male or female, and other supporting staff. In many States there is a shortage of lady doctors. To overcome this there is a central family planning corps of female doctors with 200 positions but only about 50 of them are filled.

It is estimated that the number of women doctors in India is 17,000. The family planning programme needs only 8,000, but generally women doctors are reluctant to work in the family planning programme.

3. Officer-in-charge, Medical Lecturer-cum-Demonstrator, Health Education Instructor, Social Science Instructor, Statistician, Public Health Nurse Instructors and Health Education Extension Officer are taken into account for the purpose of calculation of the table.

4. Persons taken into account for consideration are : Family Planning Officer, Assistant Surgeon, Health Educators and Social Workers.

The following table gives the staff position of the major categories[5] of district personnel:

No. of persons required	No. of persons in position	Gap
4,208	2,308	1,900
	55 %	45 %

Block and Sub-block Personnel: There is a PHC for a population of 100,000 or roughly one per block with sub-centres at the rate of one per 10,000 population. There is need for 5,432 PHCs but only 4,182 are now functioning with 28,912 sub-centres.

Urban Family Planning Centres: There are 1,775 urban family planning centres out of a target of 1,856—a gap of 81 centres.

From the foregoing analysis of manpower requirements we know that there are some vacant positions. Functions pertaining to such unfilled positions are performed partially by others.

The causes are:

1. There is a dearth of doctors, especially lady doctors, in this programme.
2. There are no adequate training facilities for paramedical personnel such as auxiliary nurse-midwives (ANMs), lady health visitors (LHVs) and health assistants and the trained personnel are short of the programme requirements.

5. The major categories are : Family Planning Officer, Administrative Officer, Mass Education & Information Officer, Assistant Surgeon (Male), Assistant Surgeon (Female), District Extension Educator (Male), District Extension Educator (Female), Statistical Investigator, ANM, Family Planning Field Worker (Male) and Family Planning Field Worker (Female).

3. In States like Rajasthan, Bihar and others, young girls with high school qualifications from rural communities are not available and urban girls are reluctant to serve in rural areas.

4. In many States the posts of demographers, statisticians, extension educators and others are vacant. For each category of post, basic qualifications have been fixed and it should not be difficult to find suitable candidates.

Training Subsystem

There are five central training institutes—the Central Health Education Bureau, New Delhi, the Gandhigram Institute of Rural Health and Family Planning, Gandhigram, the All India Institute of Hygiene and Public Health, Calcutta, the National Institute of Family Planning, New Delhi, and the Family Planning Training and Research Centre, Bombay. There are also the National Institute of Health Administration and Education, New Delhi, and the Demographic Training and Research Centre, Bombay, training the personnel of the programme. All these training institutes are at the central level. In the Fourth Five Year Plan it is proposed to have a planning action and research institute at Lucknow as an additional central training institute.

It is the responsibility of the central training institutes to provide leadership in their regional areas through technical assistance, support and guidance in States and help develop a systematic Statewide training capabilities.

At the State level there are 44 out of 46 Regional Training Centres which also cater to the training needs of this programme..

The administrative and top personnel are trained by the central training institutes and the block level personnel by the 44 regional (State) training centres. In addition to central institutes, there are 16 mobile units which train sub-centre personnel such as ANMs, LHVs, etc. This training is an

in-service training. Pre-service is given in medical colleges and training schools for ANMs, LHVs and sanitary inspectors and others.

There is a Deputy Commissioner in charge of the Training Division in the Department of Family Planning. Some of his functions are :

1. Co-ordination of the central training institutes as a regional network.
2. Provision of continuing education and staff development for trainers, etc.

It is the duty of the Training Division to screen all the research projects after they are cleared by the Indian Council of Medical Research and the Demographic Communication Action Committee.

So far, according to the data available, up to March, 1969, the personnel trained by the five central institutes are 6,419.

The following are the problems of training in the family planning programme of India:

1. There is no sanction of required staff in medical colleges to teach various facets of family planning at the undergraduate level. In the basic training of ANMs, LHVs, etc., the position is still sketchy and lacks practical field training.
2. Various categories of persons recruited to the family planning programme have either little or no pre-service training.
3. Untrained teachers at the training centres.
4. Job description and job performance of various categories are not clearly defined.
5. The trainers have a low professional status.
6. Management skills are not imparted to administrators and programme planners.
7. Frequent transfers or resignation of trained persons.
8. Reluctance of field supervisors to release persons for training due to pressure on them to achieve targets.

9. Eight per cent of the personnel who were supposed to be employed to enable steady release of personnel for training are not employed.

Communication Subsystem

There is a Mass Education and Media Division within the Department of Family Planning which is responsible for mass communication. It is done through wall posters, paintings, etc. Slogans such as "Two or three are enough" are advertised in buses, on railway platforms, on the back of the match boxes and in many other places. Red Triangle is the symbol which speaks of the family planning programme in India. Of late, there are new slogans which speak about spacing, i e., "this is not the time for one more child". and "after two never". All these techniques are used to create a general awareness among the people about the family planning programme in India. The Central Government provides all the budget for the mass education and communication subsystem (personnel, equipment, material production, etc). States are just implementing agents of this subsystem and distributors of family planning material among the people.

There are cells within each All India Radio station exclusively for family planning broadcasting. There are 30 audio-visual cinema vans in addition to 336 mobile audio-visual units. The Ministry of Information and Broadcasting provides services like advertising, Press information, etc. But often it seems that there is lack of co-ordination in the desired efforts of the Ministry of Health and Family Planning and the Ministry of Information and Broadcasting. This problem needs to be looked into.

We also need to know what is the pattern of diffusion process from the urban to the rural community for building an effective communication subsystem at the grass-root level. Pertinent to this is the feasibility to attain the target reduction in fertility within the existing system and the reason for success or failure.

There are limitations on the free flow of information in India due to the vast size of population, the low levels of

education, resistance to change, and more or less absence of major mass media, i.e, Press, radio and motion pictures—among the 80 % or more of the rural population.

Information Subsystem

For an effieient management of any programme, adequate information is required by programme managers on aspects sueh as (a) whether a programme is progressing satisfaetorily, (b) if not, why, (e) how to improve the performanee of a programme and (d) how to implement neeessary ehanges without any undue delay.

There is a detailed series of reeords, registers, ete., whieh have been worked out by the Central Government. This brings out the performanee of the family planning programme at various levels. There is also a standardized proforma for the eolleetion and transmission of monthly data on various efforts made by the family planning programme and its aehievement at different levels right from the bloek to the Central level. The information originates from the peripheral field workers and is sent to PHCs which, after eonsolidation, pass it to the distriet bureaus. These bureaus send the consolidated information to the State Bureaus whieh in turn send it on to the Centre after consideration and finalization.

Each peripheral unit is required to maintain: (a) daily ease register, (b) IUCD register, (c) eonventional eontraeeptive eouple register, ete., which are the basis of monthly reports. Most of these registers are not properly maintained due to laek of supervision, supply of forms or stationery, and training of motivators. In all, a field worker has to maintain seven to eight registers.

Besides, there are two other registers: (a) individual ease cards for male sterilization, female sterilization and IUCD insertions, and (b) eligible eouple register whieh is kept by the family planning health assistant for his motivational and referral work. These registers are maintained for follow-up purposes and motivational work.

Due to the need to maintain a multiplieity of reeords most of the time of the workers is spent on them and eonsequently

they cannot pay adequate attention to other important work such as motivation, education, etc.

If any delay occurs in the handling and submission of returns by various units, it is checked by the control registers kept at every receiving unit. Each unit is also supposed to hold regular monthly meetings at district level with the personnel from PHCs. These meetings are meant to review and discuss various administrative problems as are related to the reports submitted.

A State family planning bureau in its monthly memorandum gives ranks to all district family planning bureaus depending on the performance relative to the target. District bureaus with high achievements are encouraged. The low-ranking districts are questioned for their poor performance. However, ranking is done on the basis of performance, and the cost and utilization are not taken into account.

The reporting system does not take into account the cost data along with the performance data. Specially at district level, data on cost and capacity utilization are collected separately from performance data. The accountant who keeps the cost data and the statistician who keeps the performance data need to co-ordinate their activities and the district family planning officer should use the data received for an analysis of the performance.

A recent World Bank report has recommended establishment of a population centre to be attached to State Secretariats for the purposes of developing a management information evaluation system.

Issues for discussion are:

a. What should be the functions of a population centre, if established, as a parallel organization?

b. What relationship it should have with the Government to avoid becoming another bureaucratic block in the machinery of the Government?

Questions And Issues

From the point of view of systems applied to family planning the following issues come up for consideration:

1. What should be the unit or model for analysis at the national, State and other levels where the programme is being administered?
2. Since the Centre is all "staff" and the "line" responsibility rests with the States and other organizations, which subsystems require a closer examination for the purpose of improving management?
3. Which other subsystems should be examined?
4. What is the control system of the Centre and the States?
5. Which variables are now found favourable to family planning and how can they be utilized to the advantage of the programme?
6. What policy aspects arise for consideration when we consider the overall objectives of the total family planning system?
7. What type of a systems model can be developed for special areas beset with special problems?
8. Among the modern management techniques being used, do we have enough experience to proceed with a further examination of newer techniques as well as think about improving on the techniques already being used like programme budgeting?
9. What State and district-level data we have to analyse through a systems model for the programme implementation?
10. What kind of a working model should be explored for better management of the programme at the peripheral level?
11. Above all, what is the thinking and approach the programme administration should adopt at this juncture in the background of the systems and other modern management practices?

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